Data Exchange Framework (DxF)

Stakeholder Advisory Committee Meeting #3

Thursday, August 20, 2026

10:00 am – 4:00 pm PT

Department of Health Care Access and Information

Agenda

Item #1	Welcome & Introductions
Item #2	Department Updates
Item #3	HCAI DxF Program Update
Item #4	Individual-Level Demographic Data and Health-Related Social Needs (HRSN) Data
Item #5	Qualified Health Information Organization (QHIO) Program Evolution Part 1
Item #6	QHIO Program Evolution Part 2
Item #7	General Public Comment
Item #8	Closing Remarks & Adjournment

**There will be public comment after each substantive agenda item in addition to general public comment.*

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Item #1

Welcome & Introductions

Jennifer Sayles, MD, MPH, Committee Chair

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Meeting Ground Rules

- Bagley-Keene Open Meeting Act will be followed.
- Members of the public can participate in person or virtually and provide public comment via either platform.
- Meeting minutes will be prepared after each meeting.
- Materials will be posted on the website.

Public Comment Opportunities

- Public comment will be taken during the meeting at designated times.
- Public comment will be limited to the total amount of time allocated for public comment on particular issues.
- The Chair will call on individuals in the order in which their hands were raised.
- Individuals are encouraged to limit their time to two minutes so we can hear from as many members of the public as possible.
- Individuals may, but do not have to, state their name and organizational affiliation at the top of their statements.

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Meeting Participation Options

- **Members who are onsite are encouraged to log in using their panelist link on Zoom.**
  - → Members are asked to keep their laptops' video, microphone, and audio off for the duration of the meeting.
  - → The room's cameras and microphones will broadcast the video and audio for the meeting.
- **Members who are joining remotely are required to keep their camera on for the duration of the meeting.**
  - → Members must announce when they are going off camera.
- **Instructions for connecting to the conference room's Wi-Fi are posted in the room.**
- **Please email Akira Vang (akira.vang@hcai.ca.gov) with any technical or logistical questions about onsite meeting participation.**

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Meeting Participation Options

Advisory Committee members and public participants may “raise their hand” for Zoom facilitators to unmute them to share comments. The Chair will notify participants/members of the appropriate time to volunteer feedback.

Onsite		Offsite	
Logged into Zoom	**Not Logged into Zoom**	**Logged into Zoom**	**Phone Only**
If you logged on from onsite via Zoom interface Press “Raise Hand” in the “Reactions” button on the screen or physically raise your hand If selected to share your comment, please begin speaking and do not unmute your laptop. The room’s microphones will broadcast audio	If you are onsite and not using Zoom For members, physically raise your hand and the chair will recognize you when it is your turn to speak. For public participants, line up at the podium and the chair will recognize you when it is your turn to speak.	If you logged on from offsite via Zoom interface Press “Raise Hand” in the “Reactions” button on the screen If selected to share your comment, you will receive a request to “unmute,” please ensure you accept before speaking	If you logged on via phone-only Press “*9” on your phone to “raise your hand” Listen for your phone number to be called by moderator If selected to share your comment, please ensure you are “unmuted” on your phone by pressing “*6”

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Public Comment

Advisory Committee Vote: Approve Meeting #2 Minutes

Item #2

Department Updates

Elizabeth Landsberg, Director

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Public Comment

Item #3

HCAI DxF Program Update and Future Discussion Topics

Michael Valle, Assistant Director
Jacob Parkinson, DxF Program Director

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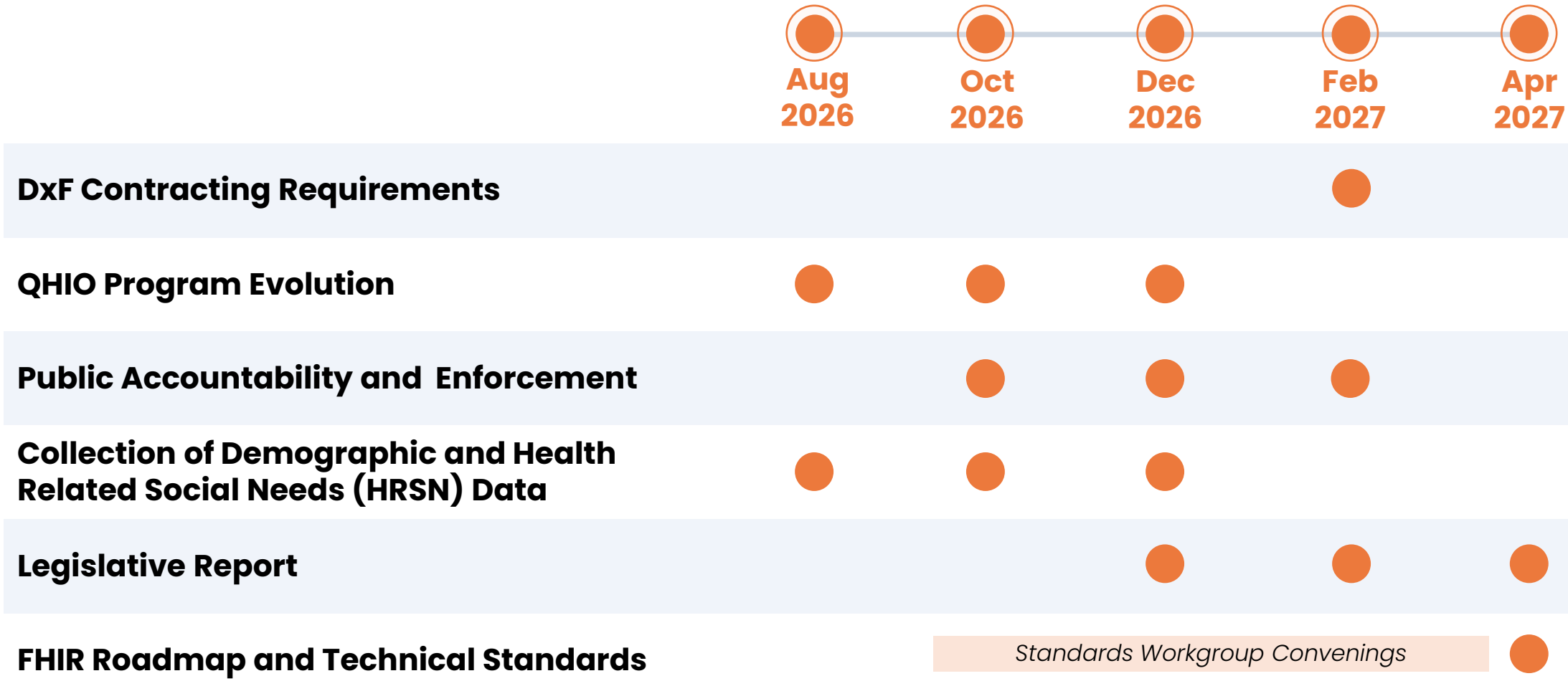
Advisory Committee Discussion Topics



Based on last meeting's vote, a draft FHIR Roadmap and Technical Standards recommendations will be reviewed with the committee in early 2027. Additional high priority discretionary items will be incorporated as time permits.

2026 DxF Standards Workgroup Application

- HCAI intends to convene a 2026 Standards Workgroup to advise on a DxF Roadmap for FHIR Adoption, including priorities for DxF use cases, adoption strategies, cost mitigation, transition from legacy standards, and an overall timeline for adoption.
- HCAI anticipates selecting approximately 15 individuals representing DxF Participants, Intermediaries, technology vendors that serve Participants, and other stakeholders with hands-on technical and operational experience implementing and adopting FHIR standards, including the financial costs and impacts of adoption.
- The Standards Workgroup will meet virtually for approximately six to eight 60- to 90-minute meetings beginning in October 2026, with the goal of reaching consensus on advice by early 2027.

The Standards Workgroup Membership Application is due Monday, August 31, 2026.

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Public Accountability and Enforcement

Jacob Parkinson, DxF Program Director

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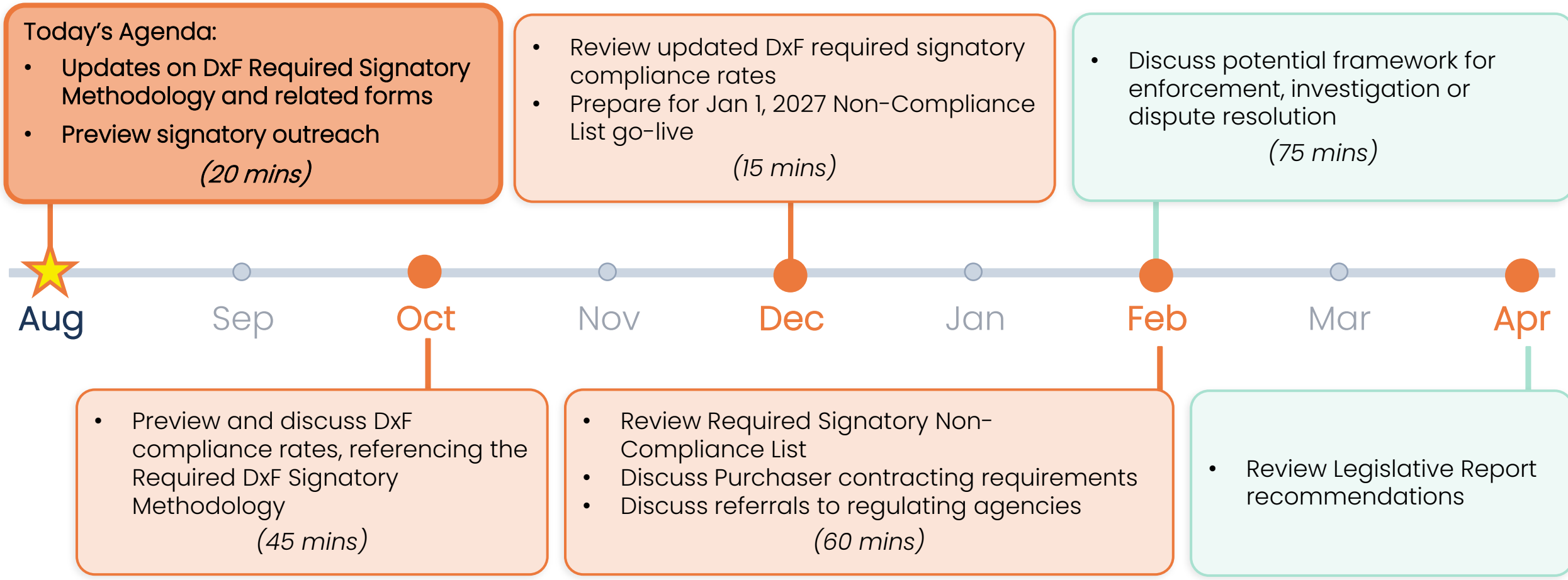
2026 Advisory Committee Meeting Roadmap: Public Accountability and Enforcement



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Public Accountability Agenda

Legislative Report Agenda

Reminder: Required DxF Signatories

California Health & Safety Code (HSC) Section 130290 (f) requires specified entities to execute the DxF Data Sharing Agreement (DSA) by January 31, 2023, July 1, 2026, or July 1, 2027.*

California HSC Section 130290 (f)

"On or before January 31, 2023, and in alignment with existing federal standards and policies, the following health care organizations shall execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to subdivision (a), except that the health care organizations in subparagraph (C) of paragraph (2) and paragraph (7) shall execute the data sharing agreement by July 1, 2026, and health care organizations in subparagraph (D) of paragraph (2) shall execute the data sharing agreement by July 1, 2027."**

Entities required to execute the DSA by July 1, 2026 include:

- Medical Foundations exempt from licensure pursuant to HSC Section 1206(l)
- Emergency medical services, as defined by Section 1797.72.***

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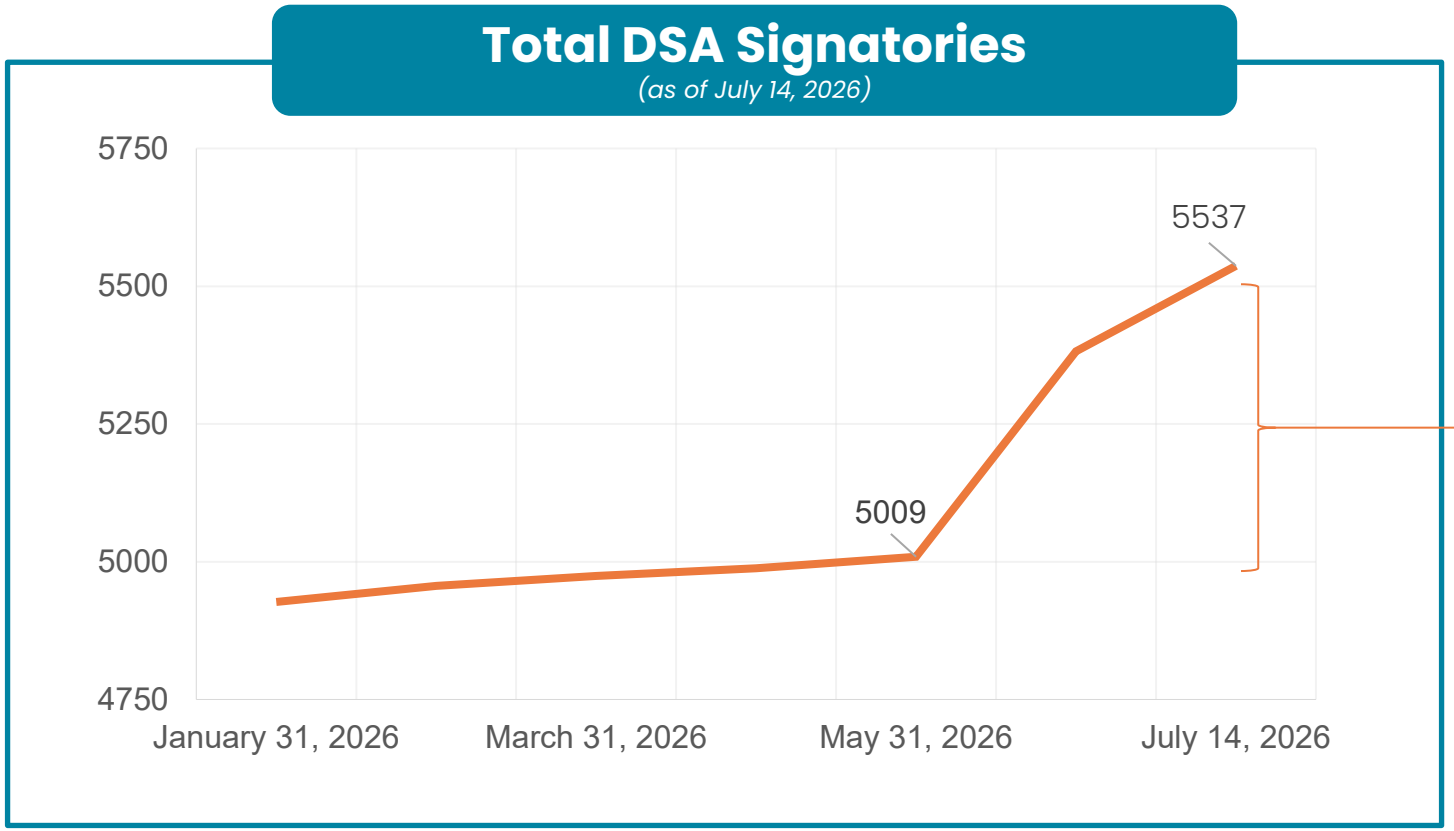
*See DxF Frequently Asked Questions #1 and #3 for more information on who is required to sign the DSA and signing deadlines.
**See Slide 16 for more information on the health care organizations subject to the July 1, 2027, deadline.
***See DxF Frequently Asked Questions #2 for more information on required EMS signatories.

Update: New DxF Signatories

California (CA) Senate Bill (SB) 660 required Medical Foundations and Emergency Medical Services (EMS) to sign the DSA by July 1, 2026.*



Between June 1, 2026 and July 14, 2026, **528 entities signed the DSA**, including**:

- 128 Ambulatory Care Providers***
- 105 EMS Providers
- 68 Social Service Organizations
- 59 Ancillary Care Providers
- 48 Community Based Organizations
- 12 Public Health Agencies

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*See DxF Frequently Asked Questions #1 -#3 for more information on who is required to sign the DSA and signing deadlines.
**108 other organizations include acute care settings, health plans, counties, parent organizations – not exchanging data, subacute care facilities, and unspecified
***Includes Medical Foundations

Update: Changes to DxF Signing Deadlines

On June 30, 2026, the 2026 health budget omnibus trailer bill (SB 164) amended Health and Safety Code Section 130290(b) and (f) to extend the deadline for select entities to execute the DxF DSA and begin exchanging.

The deadline to execute the DxF DSA and begin exchanging was extended to July 1, 2027, for the following entities*:

- Community clinics licensed under subdivision (a) of Section 1204,
- Intermittent clinics exempt from licensure under subdivision (h) of Section 1206; and,
- Rural health clinics as defined in paragraph (1) of subdivision (l) of Section 1396d of Title 42 of the United States Code

The following DxF resources are being amended to reflect these changes:

- Participant Directory P&P
- Requirement to Exchange Health and Social Services Information (HSSI) P&P
- FAQ #3 (DxF DSA Signing Deadlines for Required Signatories)

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**California HSC Section 130290 (as amended by Stats. 2026, Ch. 27, § 55 (SB 164, Committee on Budget and Fiscal Review), effective June 29, 2026).*

Reminder: DxF Accountability Requirements

HSC Section 130290(k) requires HCAI to publicly share the names of any known entities deemed non-compliant with the requirement to execute the DxF DSA and submit a report to the Legislature with additional recommendations regarding DxF accountability.

Non-Compliance Posting*

"Commencing **January 1, 2027**, the department shall publish and keep current on its internet website the names of any known entities the department deems not to be in compliance with the requirement to execute the California Health and Human Services Data Exchange Framework data sharing agreement pursuant to subdivision (f)"

Report to the Legislature**

"In collaboration with the stakeholder advisory group, the department shall develop and submit a report to the Legislature by **July 1, 2027** [...] that includes all of the following:"***

- List of all general acute care hospitals, skilled nursing facilities, and health plans required to sign the DSA, status of each entity's execution of the DSA, the compliance pathway(s) these required signatories utilized to meet their contractual obligations under the DSA, and whether the signatory has a contract in place with a state purchaser
- Evaluation of whether other categories of entities should be required to participate in the DxF
- Evaluation of need for a framework for enforcement, investigation, and dispute resolution

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**California HSC Section 130290(k)(2) (as amended by Stats. 2025, Ch. 325, § 1 (SB 660, Menjivar), effective January 1, 2026).*
***California HSC Section 130290(k)(4) (as amended by Stats. 2025, Ch. 325, § 1 (SB 660, Menjivar), effective January 1, 2026).*
****This excerpt highlights selected SB 660 reporting requirements related to public accountability and is not a comprehensive list of all required report components.*

DxF Required Signatory Methodology and Related Forms

HCAI is publishing three resources to support signatories in understanding which entities are required to comply with SB 660 DxF DSA signing requirements, and to allow for entities to attest that they are in compliance or not required to sign, or explain any circumstances for non-compliance.

1. The DxF Required Signatory Methodology outlines the data parameters HCAI uses to determine required signatories by entity type as defined by HSC Section 130290, subdivision (f).
    - The methodology relies on public data sources, including California licensing and regulatory data, and is informed by stakeholder feedback, including review by state associations representing providers.
    - HCAI continues to develop and refine the methodology as licensing, regulation, and stakeholder feedback evolve.

Required DxF Signatory Methodology and Related Forms (cont.)

HCAI published three resources to support Signatories in understanding which entities are required to comply with SB 660 DxF DSA signing requirements, and to allow for entities to attest that they are in compliance or not required to sign, or explain any circumstances for non-compliance.

2. The Non-Required Signatory Attestation can be submitted if an entity can attest that they are in compliance or not required to execute the DxF DSA and why.

3. The Statement of Extenuating Circumstances can be submitted if an entity wishes to provide an explanation of the circumstances impacting its ability to comply with the DxF requirement to execute the DxF DSA. HCAI will publish:

    - Standard Operating Procedures (SOPs) to describe the intake process for both forms

    - Statements on the DxF website

Signatory Outreach Efforts

HCAI is conducting a phased, multi-channel outreach campaign in 2026 to communicate the requirement to execute the DxF DSA to specified entities.

- **Coordinate with state associations representing providers** to socialize the Required Signatory Methodology, and provide educational materials for member communications
- **Explore opportunities to collaborate with regulating agencies** to communicate the requirement to sign the DxF DSA requirements to specific entities
- **Conduct initial outreach** to entities HCAI believes may be required signatories that have not yet signed the DSA to inform them of California HSC Section 130290 (f) requirements and the January 2027 noncompliance list and support their signing of the DSA *(August)*
- **Conduct ongoing education and outreach** informed by Signatory progress in advance of January 2027 *(September – December)*

Public Comment

Item #4

Individual-Level Demographic Data and HRSN Data

Jacob Parkinson, DxF Program Director

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SB 660 Requirement and Committee Charge

- SB 660 requires the DxF Stakeholder Advisory Committee, by January 1, 2027, to develop recommendations related to the collection of individual-level demographic and health related social needs (HRSN) data.
- The recommendations may address:
  - Training and technical assistance
  - Best practices for data collection
  - Potential statutory changes
- Today's discussion will establish the current-state landscape and key issues to inform recommendations for the Committee's future consideration.

Source: Health and Safety Code § 130290(c)(6)

Current DxF Policy Requires Exchange, Not Collection

What the DxF Requires

- Required entities and voluntary signatories must exchange specified information with other Participants
- Exchange applies when the information is maintained by the Participant and sharing is permitted by law
- Participants may use any exchange pathway that meets DxF requirements

What is Outside of the Scope of DxF Policy

- Collection of demographic or HRSN data that a Participant does not maintain
- Use of a uniform demographic questionnaire or single HRSN screening tool/collection workflow

DxF requirements determine what data must be exchanged if available, not what data organizations must collect in the first place.

Source: Health & Safety Code § 130290(a)(4), (b), and (f); DxF Data Elements to Be Exchanged P&P, § II.1; DxF Requirement to Exchange P&P, §§ III.1 and III.3.

Current Standards for Demographic and HRSN Data Exchange

United States Core Data for Interoperability (USCDI) v3 includes standardized elements related to:

- Race, ethnicity, and Tribal affiliation
- Sex, sexual orientation, and gender identity
- Preferred language
- Disability status

USCDI v3 uses "social determinants of health (SDOH)" terminology and includes:

- SDOH assessments
- SDOH problems or health concerns
- SDOH goals
- SDOH interventions

USCDI standardizes data for access, exchange, and use; it does not require entities to collect every element or conduct HRSN screening.

Source: ASTP/ONC, USCDI v3, October 2022 Errata; 45 C.F.R. § 170.213(b); DxF Data Elements to Be Exchanged P&P, § II.2.a.

Federal Standards and the Evolving Treatment of SOGI Data

Current Federal Baseline:

- The current federal certification baseline is USCDI v3, which includes sexual orientation and gender identity.
- The DxF references this federal certification baseline for exchange standards.

Federal Standards are Evolving:

- A proposed rule, HTI-5, would replace USCDI v3 with v3.1, revising certain sex, sexual orientation, and gender identity elements.
- Standards Version Advancement Process (SVAP) allows certified health IT developers to voluntarily adopt approved versions newer than the required USCDI v3 baseline, including versions reflecting v3.1's revisions to sex, sexual orientation, and gender identity.

The Committee may need to consider how California collection standards should address SOGI data if the federal exchange baseline changes.

Source: 45 C.F.R. § 170.213(b); DxF Data Elements to Be Exchanged P&P, § II.2.a; 90 Fed. Reg. 60970, 60981, 61000 (Dec. 29, 2025) (proposed rule); ASTP/ONC, *ONC Standards Bulletin 2025-2*

Path to Recommendations

August: Establish the Current-State Landscape

- Establish the current-state collection landscape
- Hear on-the-ground perspectives
- Surface initial priorities and promising practices

October: Develop and Discuss Potential Recommendations

- Consider potential recommendations and best practices
- Assess feasibility and implementation implications
- Identify areas of agreement and outstanding questions

December: Finalize Proposed Committee Recommendations

- Refine proposed recommendations
- Formally vote on proposed recommendations

California Pan-Ethnic HEALTH NETWORK

DxF Stakeholder Advisory Committee Meeting

August 20, 2026

Cary Sanders/Senior Policy Director, CPEHN

Ignatius Bau/Policy Consultant, CPEHN

AGENDA

- CPEHN: Who We Are
- SB 660 Requirements
- Methodology for Key Informant Interviews
- Themes from Key Informant Interviews

About CPEHN

- CPEHN is a statewide health advocacy organization.
- **Our Mission:** The California Pan-Ethnic Health Network brings together and mobilizes communities of color to advocate for public policies that advance health equity and improve health outcomes in our communities.
- **Our Approach:**
  - Policy Advocacy
  - Network Building
  - Policy Research
  - Storytelling

California Pan-Ethnic HEALTH NETWORK

CPEHN ensures health justice and equity are on the agendas of policymakers and that communities are part of the policymaking process

We build people power *to educate and influence policymakers through lived experience, disaggregated data, and community expertise for better health equity centered policies and systems*

We pass, change, and implement policies *that reflect community needs for better health*

We invest in communities of color *to build leadership, sustainability, and advocacy strength*

We connect *data, stories, partners, and regions to build knowledge, relationships, and understanding across cultures*

To create equitable conditions *that promote health equity and allow communities of color and all residents to thrive and prosper*

SB 660 Requirements

- The advisory committee must develop recommendations by January 1, 2027 for statutory changes, training and technical assistance, and best practices for data submitters to collect individual-level demographic and health-related social needs data about Californians served [HSC 130290(c)(6)]

California Pan-Ethnic HEALTH NETWORK

Rationale for Demographic and HRSN Data as Part of Data Exchange

- There is persistent evidence of health inequities based on demographics and health-related social needs
- No single provider, systems, or sector can eliminate those inequities by themselves
- Data exchange allows all providers, systems, and sectors to see all the clinical (and social) needs of each person, and work together to address them

Methodology

- Key informant interviews were conducted between June-July 2026
- Interviewees included individuals from public and private purchasers, health plans, hospital associations, clinics and physician practices, community-based health and social services organizations
- Not comprehensive or representative of the health care sector, but commonality in several themes

Themes from CPEHN Interviews: Overview: REaL and HRSN Data

- All are committed to health data exchange to improve quality (and advance equity)
- All are committed to collecting, sharing, and using demographic data
- Race and ethnicity data is the most complete, followed by language data
- All understand the importance of collecting, sharing, and using data about health-related social needs

Themes from CPEHN Interviews: SOGI and Disability Data

- Most have begun to collect sexual orientation and gender identity data, but data far from complete
- Many have concerns about continuing to collect and use sexual orientation and gender identity data
- Few are collecting disability data; some are just beginning to explore disability data collection

Themes from CPEHN Interviews: Context of Current Environment

- Almost all interviewees referenced expected organizational resource constraints, especially from implementation of H.R. 1, with decreased Medi-Cal enrollments/payments and increased uncompensated care
- Many have concerns about privacy: mitigating organizational risks and shielding data from federal inquiries and investigations, especially gender identity data
- Many are hearing privacy concerns from patients, members, and community members about immigration enforcement and trans health care; with AI, others have concerns about who “owns” and will use their data

Themes from CPEHN Interviews: Operational Concerns about Data Exchange

- There is inconsistent knowledge about data exchange and its potential use cases
- Data exchange is often uni-directional, e.g. receiving admissions/discharge or HRSN data from hospitals
- Small physician practices are generally not using data exchange in a meaningful way
- Social services organizations, e.g. participating in CalAIM, are generally not using data exchange but are working on closed loop referral systems

ABFM Data: How HRSN Information is Documented in Practice

To help illustrate the current state of HRSN data collection, HCAI reviewed selected 2024 data from the American Board of Family Medicine (ABFM) Continuous Certification Questionnaire.

The questionnaire asks physicians how often they document screening for social needs, such as transportation, housing, and food insecurity, using different methods within the electronic health record (EHR).

2024 California Responses: 1,158 Family Medicine Physicians			
Method of Documenting HRSN Screening	**Often/Sometimes**	**Rarely/Never**	**Don't Know/Don't Use EHR**
Writing in a Clinical Note	56%	33%	11%
Entering as a Diagnosis Code	35%	52%	13%
Using a Box or Button in the EHR	25%	51%	14%

What the Data Suggest:

- HRSN information is more commonly documented in clinical notes than through structured EHR fields or diagnosis codes
- Unstructured documentation can make it more difficult to standardize HRSN information and exchange it across organizations involved in an individual's care.

Source: American Board of Family Medicine Continuous Certification Questionnaire, 2024

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Connecting San Diego

A holistic overview of the Community Information Exchange (CIE) and social care data interoperability

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THE CIE PARADIGM

Community Information Exchange® (CIE)

A CIE is an ecosystem of multidisciplinary partners using a shared language, a resource database, and interoperable technology platform to coordinate care.

Care planning tools enable partners to integrate key SDOH data from multiple sources, make bi-directional referrals, and create a shared, longitudinal record that enables informed care.

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Core Pillars of the CIE Network

Network Partners

Collective approach supported by shared governance, Participation and Business Associate Agreements, participant consent, and ongoing partner engagement and support.

Shared Language

Establishes a standardized framework of measures using 14 Social Determinants of Health assessments and a universal crisis-to-thriving scale.

Bidirectional Referrals

Bridges care groups to deliver real-time closed-loop tracking, outcomes reporting and program enrollment verification.

Technology Platform and Data Integration

Technology software that integrates with other platforms to populate an individual record and shapes the care plan. System features include care team communication feeds, status change alerts, data source auto-history and predictive analytics.

Community Care Planning

Longitudinal record with a unified community care plan that promotes cross-sector collaboration and a holistic approach.

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Primary CIE Uses

Searching patients/members to see historical use of social services

- Tailor services accordingly
- Reach out to existing care team member or agency for support

Make referrals to external community and healthcare organizations

- Ability to track referrals to partners
- Send client profile directly to agency (outcomes of referral)

Shared screening or prioritization of resources

- Example--Homeless Prevention resources
- Prioritize access to services (history or acuity)

Receive alerts to be proactive or response

- Join as care team member and receive alerts

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What Problems are We Trying to Solve

Care Coordination

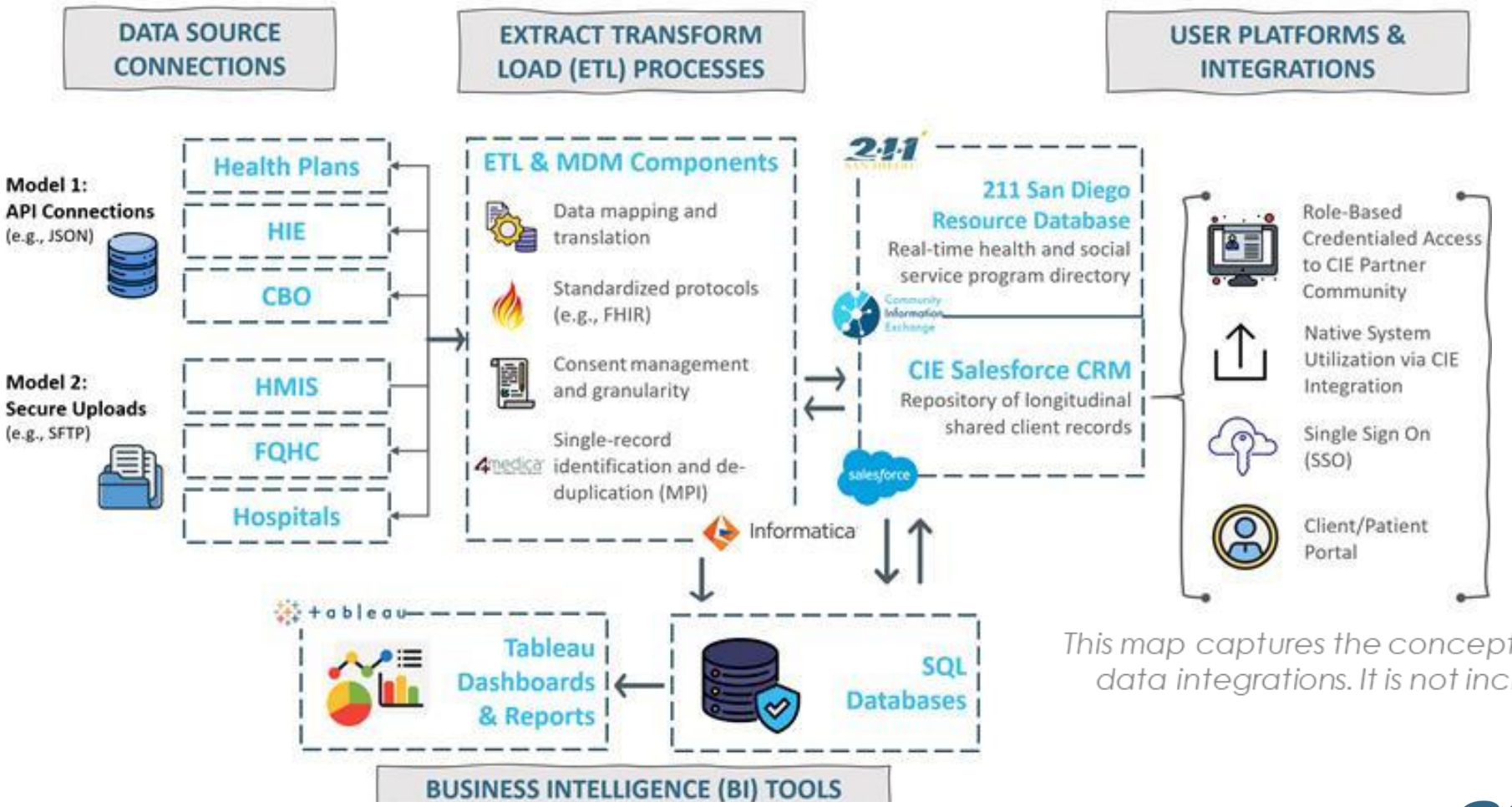
- **Unmet social needs impact whole person health**
  Factors like affordable housing, safe transportation, and the built environment have twice as much of an impact on a person's well-being as clinical care

- **Current social and health care delivery systems are fragmented**
  Data systems are siloed and providers rarely have the information they need in one system to make informed decisions about a client's holistic health and well-being

- **The burden of social care often lies on the person in need**
  People have to recall traumatic experiences repeatedly, coordinate their own care, and repeat information to multiple providers

- **Systems can perpetuate and exacerbate racial and other inequities**
  The most impacted populations are left out of decision-making and designing service delivery and systems of care

CIE Technical Architecture



This map captures the conceptual framework for data integrations. It is not inclusive of all active integrations.

Care Coordination Driving Data Integration and Systems interoperability

	LOW-END DATA INTEGRATION ⟷ HIGH-END DATA INTEGRATION					
UTILIZATION MODEL	**#1 Direct use of CIE portal**	**#2 CIE as a space for multi-agency shared purpose and workflows**	**#3 Integration-enabled use of CIE functions for care coordination**	**#4 Using CIE functions from native system workflows via data integration**	**#5 CIE insights in native system via data integration**	**#6 Contributing data to CIE**
WORKFLOW	Manual	Manual + data share	Using CIE with no duplicative data entry	Using native system only via data share	New data from shared clients via data share	New data shared to enable others to provide care coordination
METHOD OF SHARING	• Manual client record creation and edits • Care coordination functions completed in CIE portal • Data entry by Individual user	• Specific data shared via API or batch uploads to accomplish shared goal across multiple organizations • Manual data entry in CIE by individual users	• Bi-directional data sharing through API mutually updates native system and CIE • Single-sign-on for CIE facilitates adoption	• Bi-directional data sharing through API mutually updates native system and CIE • Data sharing is limited to functionality within native system • Not logging in to CIE	• Data integration triggers CIE functions behind the scenes and allows bi-directional data flow via real-time API connection	• Sends data to CIE to populate client records through batch data sharing and real-time API connections (i.e., HMIS)
ORG USECASE	• No system integration • Adopt use of CIE for care coordination	• Partners with limited internal system capability and/or need use CIE as a shared, collaborative space with some data sharing	• Leverage native system and CIE functionality	• Using native EHR and leveraging CIE functionality through data integration sharing • Not accessing the full CIE longitudinal record	• Bi-directional data sharing between CIE and native system	• Expanding network-wide visibility and data completeness of client records • Strengthens informed care based on data shared populated shared record
VALUE & IMPACT	• Full access to the CIE Longitudinal Record • Full use of CIE functions • Micro level care coordination enabled	• Shared outcomes and data analytics • Micro and Mezzo level care coordination enabled • Same as #1	• Data enrichment of native system from CIE client record, referral outcomes and history without manual lift • Micro and Mezzo level care coordination enabled • Same as #1 and 2	• Leverage specific CIE functionalities like closed-loop referral • No need to adopt additional system • Micro and mezzo level care coordination enabled • Same as #3	• Gain insights on shared clients (i.e., SDOH needs to inform presumptive eligibility) • Mezzo level care coordination enabled	• Mezzo and macro level care coordination enabled and improved

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San Diego Examples

Data Integration and System Interoperability

Social Service Providers: Care Coordination driven interoperability

- Local CBO - San Diego Rescue Mission *(Mission Tracker – national social service platform)*
- Local Public Housing Authority - San Diego Housing Commission *(Salesforce)*
- HUD CoC - Regional Taskforce on Homelessness *(HMIS – BitFocus/Clarity)*

Hospitals, FQHCs, & MCOs:

- Local Health System - UCSD Health *(EHR - Epic)*
- Local Health System/Payor - Kaiser Permanente *(Unite Us)*
- Medi-Cal Managed Care Plan - Blue Shield of CA Promise *(Care Connect/Experience Cube)*

QHIO - San Diego Health Connect (HIE)

- Shared MPI / SDoH Portal to CIE
- EMS transport data and Care Team alerts *(EMS, WIC)*

Examples of Key Data Needed for Care Coordination

Identifiers	System ID First name Middle name Last name Date of birth Last 4 SSN Full SSN
Demographics	Preferred/primary language Gender Sexual orientation Race Ethnicity Veteran status Highest level of education
Contact Information	Email Home phone Mobile phone Mailing address Mailing city Mailing ZIP code Physical/home address Physical/home city Physical/home ZIP code

Employment, Income, Benefits	Employment status Monthly income Sources of income Non-cash benefits *Benefit Renewal Date (Medi-Cal)* *Renewal Date (CalFresh)*
Housing and Homelessness	Housing status History of homelessness Chronicity of homelessness
Household Information	Household type Household size # of children and ages/DOB # of children under the age of 5 Household members name Household members contact information Guardian/conservator/caregiver relationship to client Client role to household member(s) Household Income

Health and Disabilities	Health condition Disabling condition ADL abilities/level of need
Insurance	Insurance type Insurance provider *Medi-Cal Member Client Index Number (CIN)* Referral Authorization Status Assigned PCP NPI ECM/CS Status
Social and Legal Factors	Justice involved Release Date

Data Asset Mapping & Standardization

Transforming Community Care through Shared Client Records:

San Diego Region Data Infrastructure Asset Map

Executive Summary

Medi-Cal stakeholders across the San Diego region have been collaboratively planning for a number of Medi-Cal Transformation initiatives, including Enhanced Care Management (ECM) and Community Supports (CS) to address both the clinical and non-clinical needs that contribute to high-need members' health outcomes.[1] In the past few years, these initiatives have increased the demand on the region's existing data exchange infrastructure and created new opportunities for cross-sector partnership. To address regional demand, 2-1-1/CIE San Diego requested funding from the DHCS CalAIM Incentive Payment Program (IPP) to create a point-in-time asset map of the region's current data infrastructure and a roadmap to guide stakeholders' efforts to effectively—and appropriately—leverage exchange healthcare and social services data within the ecosystem to support improved care coordination.[2]

Existing Data Infrastructure

San Diego is home to robust, local data infrastructure, including the Community Information Exchange (CIE) and San Diego Health Connect, the local health information exchange (HIE). Both were established over a decade ago to support data sharing among health and social services providers. San Diego also has Health Center Partners, a consortium of FQHCs that are working toward improving population health. Innovation partners like the Regional Taskforce on Homelessness have established data sharing with CIE. Additionally, the County of San Diego Health and Human Services Agency (HHSA), the Hospital Association of San Diego & Imperial Counties and other key stakeholders are working collaboratively to improve the larger system of care.

San Diego's Community Information Exchange (CIE) began in 2011 as a collaborative approach to sharing basic client-level data between service providers in San Diego. Over time, the CIE has become a catalyst for the community-based movement to understand, value and share social determinants of health data and use technology to bridge sector divides. The CIE facilitates closed loop referrals and the creation of a single, unduplicated, person-centered record and community-wide care plan. Today, San Diego's CIE is an ever-growing network of 137 health care, human and social service organizations delivering person-centered care using a cloud-based platform that allows individuals to share information about their progress toward health and wellness goals across providers through an individual, identifiable, longitudinal record.

Minimum Data Set for Cross Sector, Community-Anchored Data Sharing

Data Element	ECM services related?	Community Supports services related?	Data Source	Value | Use Case	Category	ECM CalAIM Member-Level Information Sharing[1] Dec 2024 update	Community Supports CalAIM Member-Level Information Sharing[2] Jan 2026 update	Closed-Loop Referral Implementation[3] May 2025 update	CLR Required Transmission File	DxF - USCDI[4]	2026 MDS - Priority Level For CalAIM Care Coordination
EMS Encounter	No	No	HIE or County	Whole Person Care	Encounter Data					Yes - See "Encounter Information" (type, dx, time, etc)	Recommended
Federal Poverty Level	No	No	County	Whole Person Care	SDOH					No - Not in USCDIv3	Recommended
Health indicators **[15 indicators in CalAIM DG Dec24]**	Yes	No	HIE or PCP	CalAIM Policy Required	Clinical	Table 2: Required				No - Not in USCDIv3	Minimum Necessary
Health Insurance Type	No	No	MCP	Improved CalAIM Care Coordination	Payer Information					Yes - Under Data Class Health Ins Information	CalAIM Care Coordination Priority
Health Related Social Needs	No	No	Care Team	Whole Person Care	SDOH					Maybe - If within SDOH Assessment	Recommended
Health System Utilization indicators **[6 indicators]**	Yes	No	HIE	CalAIM Policy Required	Utilization	Table 2: Required				No - Not in USCDIv3	Minimum Necessary
Historical Health Plan Information	No	No	MCP	Whole Person Care	Payer Information					No - Not in USCDIv3	CalAIM Care Coordination Priority
Historical Housing Status Time Stamps	No	No	HMIS	Improved CalAIM Care Coordination	Housing					No - Not in USCDIv3	Recommended
Hospital Discharge Diagnosis	No	No	Facility or HIE	Transition of Care	ADT | Event Notification					No - Not in USCDIv3	Recommended
Household Size	No	Yes	Care Team	CalAIM Policy Required	SDOH		Table 5: Conditional			No - Not in USCDIv3	Minimum Necessary
Housing Assessement	No	No	HMIS	Whole Person Care	Assessment					Maybe - If within SDOH Assessment	Recommended
Housing Status Flag	No	No	HMIS	Improved CalAIM Care Coordination	Housing					No - Not in USCDIv3	Recommended
In Home Supportive Services (IHSS) Enrollment	No	No	County	Improved CalAIM Care Coordination	County or State Services					No - Not in USCDIv3	Recommended
Military status	No	No	County	Whole Person Care	Member Information					No - Not in USCDIv3	Recommended
Number of Available Beds	No	No	CIE or HIE	Transition of Care	Utilization					No - Not in USCDIv3	Recommended
Outreach Attempts Method	Yes	No	MCP	CalAIM Policy Required	Utilization	Table 8: Required				No - Not in USCDIv3	Minimum Necessary
Pharmacy information and indicators **[2 in CalAIM DG Dec24]**	Yes	No	HIE or MCP	CalAIM Policy Required	Clinical	Table 2: Required				No - Not in USCDIv3	Minimum Necessary
Post Conviction Risk Assessment (PCRA)	No	No	Probation/Parole	Improved CalAIM Care Coordination	Justice Involved					No - Not in USCDIv3	Recommended

211 SAN DIEGO · Community Information Exchange · SAN DIEGO HEALTH CONNECT

Recommendations from the Field

State Data Contributions

- Interoperable access to state benefits data across departments for actionable care coordination across sectors (ex. Medi-Cal/CalFresh Enrollment, CIN #)

Consent Management Service

- Consent documentation and processes (ASCMI)
- Validation of granular consent for service/benefit access and care coordination
- HIPAA aligned "need to know" of social data within healthcare
- Address complexities of "need to know" across sectors + data sharing laws v. entity type-only + data sharing state and federal laws

Standardized Payload (Min Data Set)

- CLR-driven data sharing: intake needs more than just contact info

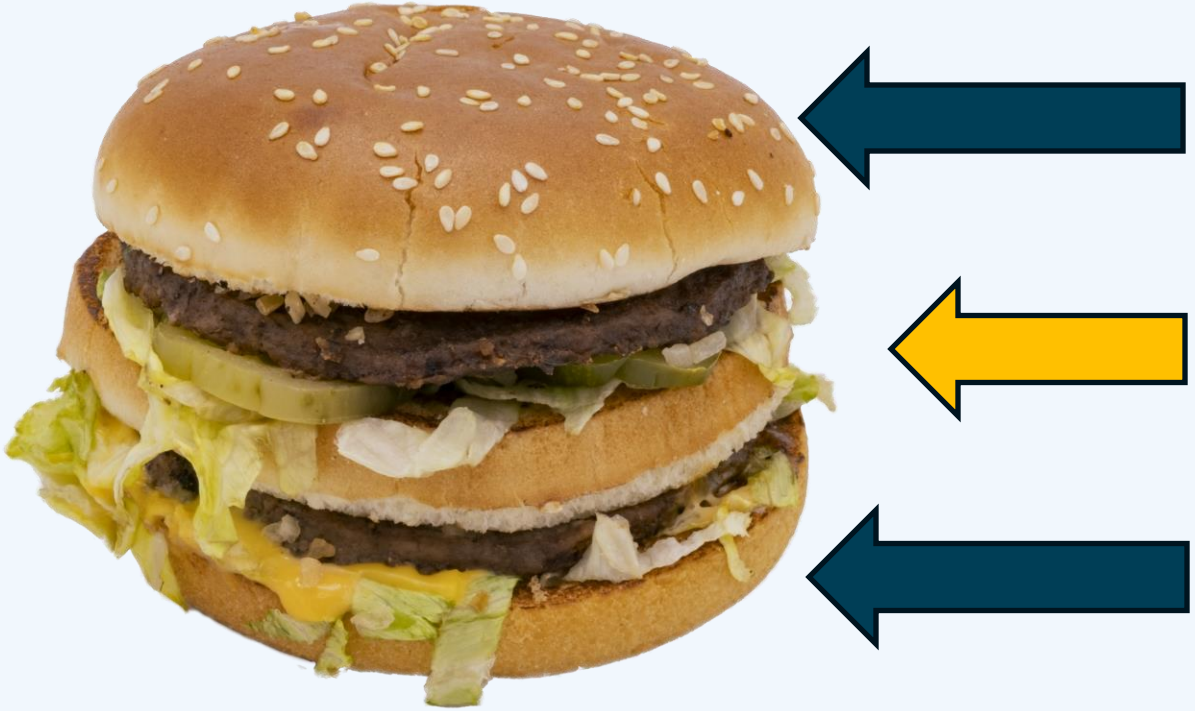
SHIE and the Data Exchange Framework

Health-Related Social Needs (HSRN) Data Exchange Implementation Journey

Alameda County Health

The Big Mac Metaphor: DxF Layers

Everyone knows what a Big Mac is. It's reliable, it's standard... but let's be honest, it's not exciting. DxF can feel the same way—everyone signs the DSAs, everyone has the compliance foundation. But **a sandwich that's only bread isn't a meal**. Where's the substance that actually feeds whole-person care? That's what we're here to talk about.



Compliance Foundation
Signed Data Sharing Agreements and technical policies

For Alameda County, this middle layer is **HRSN (Health-Related Social Needs) data exchange**

Compliance Foundation

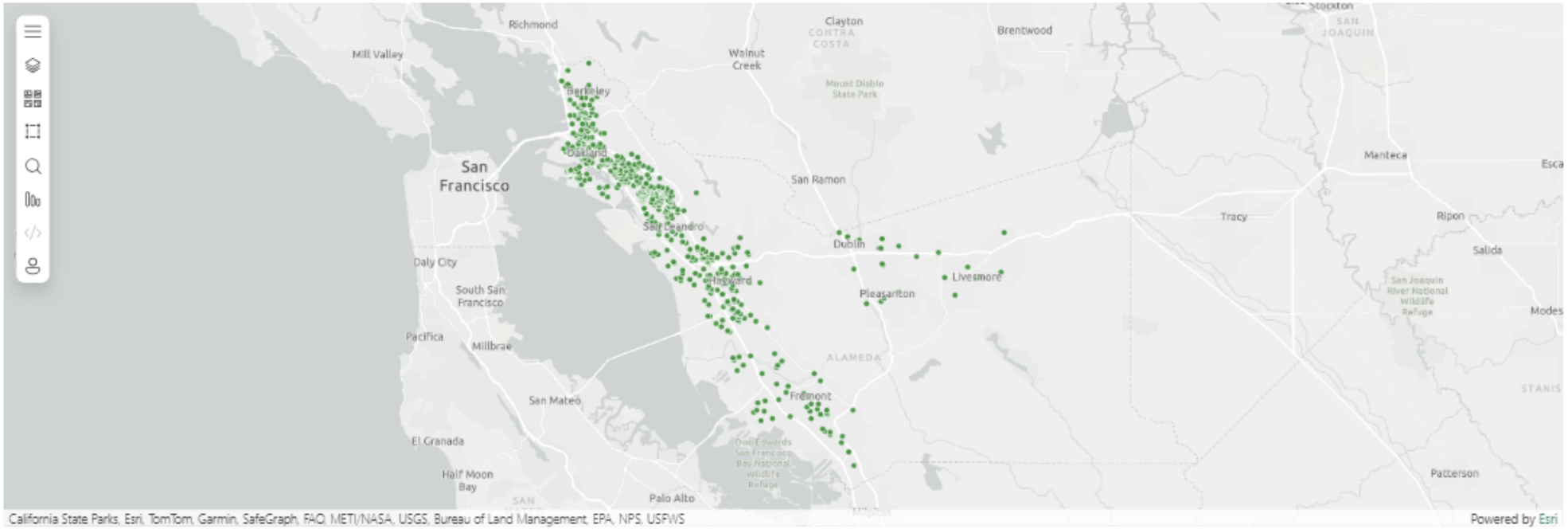
Alameda County Health

H&H Housing Map — Alameda County Consumers

Alameda County Health

778	778	100.0%	42	778
Total Consumers	Consumers With Geocode	Geocoded %	Distinct Organizations	Active Enrollments

Consumer locations (ArcGIS)



Reset filters

Alameda County
Yes

City
All

Enrollment Status
Active

Program Type
All

Age group
18-24

BOS district
All

Consumer detail — on map only (agency addresses excluded)

City	City source	Organization	Program	Status	Registered	Enrolled	Full Address	Geo readiness	On map
Alameda	ESRI	ACHCD - Housing and Community Development	Permanent Housing - Disability Services	Active	8/17/2011	9/4/2015	Redacted		
Alameda	ESRI	ACHCD - Housing and Community Development	Permanent Housing - Disability Services	Active	4/22/2015	8/24/2016			
Alameda	ESRI	APC - Alameda Point Collaborative	Permanent Housing - Disability Services	Active	6/5/2006	12/5/2008			
Alameda	ESRI	APC - Alameda Point Collaborative	Permanent Housing - Disability Services	Active	9/6/2006	5/16/2015			
Alameda	ESRI	APC - Alameda Point Collaborative	Permanent Housing - Disability Services	Active	1/2/2007	9/25/2015			

Consumer Map — FAQ

MDR (Master Demographic Repository) is the county central ESRI geocode store joined on PersonID — not a new geocode on every HMIS refresh.
Who is on the map? Active H&H consumers (HMIS Account 1014) with a residential-class address — agency/scattered-site spikes (>20 at same address) are excluded here; see Data Quality tab. City labels prefer valid ESRI matched_city (City source = ESRI); HMIS city is audit-only when a good match exists.
Alameda County defaults to Yes (MDR FIPS 06001). Use Reset filters (above slicers) to restore that default view. Clear Yes and/or check No to include out-of-county geocodes — Total Consumers should rise (~5k out of county).
Why ~6% missing coords? Mostly persons not yet in the MDR or incomplete HMIS fields. Registered = HMIS consumer registration date; Enrolled = start of the most recent attributed program enrollment (not last clinical visit). Age = completed years from DoB as of config/age_as_of_date.txt. Technical: Query 12 → join_mdr_geocodes.py → refresh. Cell suppression <10 if publishing small-area counts.

What We're Building

We’re laying the data foundation our county needs to support integrated housing, health, and social-needs analytics — and to ensure our future QHIO connection delivers real value.

1. HMIS Housing Data Infrastructure

- Integrating HMIS data across county systems
- 778 consumers actively enrolled in Housing & Homelessness programs
- Building capacity to track housing status, service utilization, and geographic need
- Geospatial proof-of-concept identifies areas where homelessness correlates with higher ER use to guide mobile health deployment

2. Internal Data Integration

- Linking housing, behavioral health, and public health data
- Developing HRSN analytics to show clinical impact
  - Food deserts affecting diabetes management
  - Transportation barriers impacting medication adherence

3. DxF Standards Adoption

- Designing with DxF standards from the start
- Preparing for Phase 1 connection to Manifest MedEx
- Enabling USCDI v4 and FHIR-compatible models without future rework
- Interoperability is built into the foundation

Alameda County Health

Implementation Challenges

1. Consent Framework Complexity

- Housing and food security data trigger HIPAA, 42 CFR Part 2, and state privacy rules
- ASCMI consent workflows require alignment across legal, compliance, and IT — slower than the tech work

Our Fix: Standardized consent templates + cross-organizational HRSN data-use agreements

Alameda County Health

Implementation Challenges

2. Cross-Departmental Data Silos

- HMIS, behavioral health, and public health operate in separate systems
- Internal data sharing requires governance structures that don’t yet exist

Our Fix: Joint use cases that show shared value (e.g., housing visibility into BH visits; public health visibility into housing status)

Alameda County Health

Implementation Challenges

3. Consent Framework Complexity

Pre-Operational Gap

- Building analytics now, but real-time care coordination can’t be demonstrated until Manifest MedEx goes live
- Leadership needs proof of concept before scaling

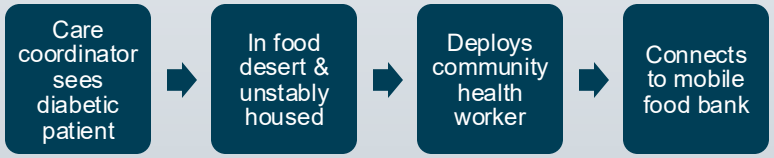
Our Fix: Phase 2–3 bidirectional QHIO exchange once external connectivity is active and outcomes are measurable

Alameda County Health

KEY HRSN INTEGRATION CHALLENGES

INTERNAL COUNTY SYSTEMS
(Our Vision–The meat in the Big Mac)

VISION: Connected Proactive Care



- Streamlined County Workflow for proactive outreach
- Rapid Patient Support (e.g., connected food & housing stability checks)

THE CRITICAL GAP

THE CRITICAL GAP

- **Crisis Discovery (e.g. 2AM ER Visits): 3-Day Delay**
- **Fragile, Non-Interop Connections (point-to-point)**

EXTERNAL DxF ECOSYSTEM
(Where we need to connect)

HOSPITAL SYSTEM

- 2:00 AM Admission (Out-of-Network)
- Hospital Clinical Data (Siloed from County Systems)

STRATEGIC SOLUTION: MANIFEST MEDEX (QHIO)

TARGET: Real-time DxF Integration

- Real-time ADT Alerts
- Multi-Directional Data Flow

Alameda County Health

Questions for the Advisory Committee

- How can we better articulate the goals of demographic and HRSN data collection and exchange?
- How does the landscape assessment of HRSN data collection we just reviewed resonate with your experience?

Public Comment

Lunch

Item #5

QHIO Program Evolution Part 1

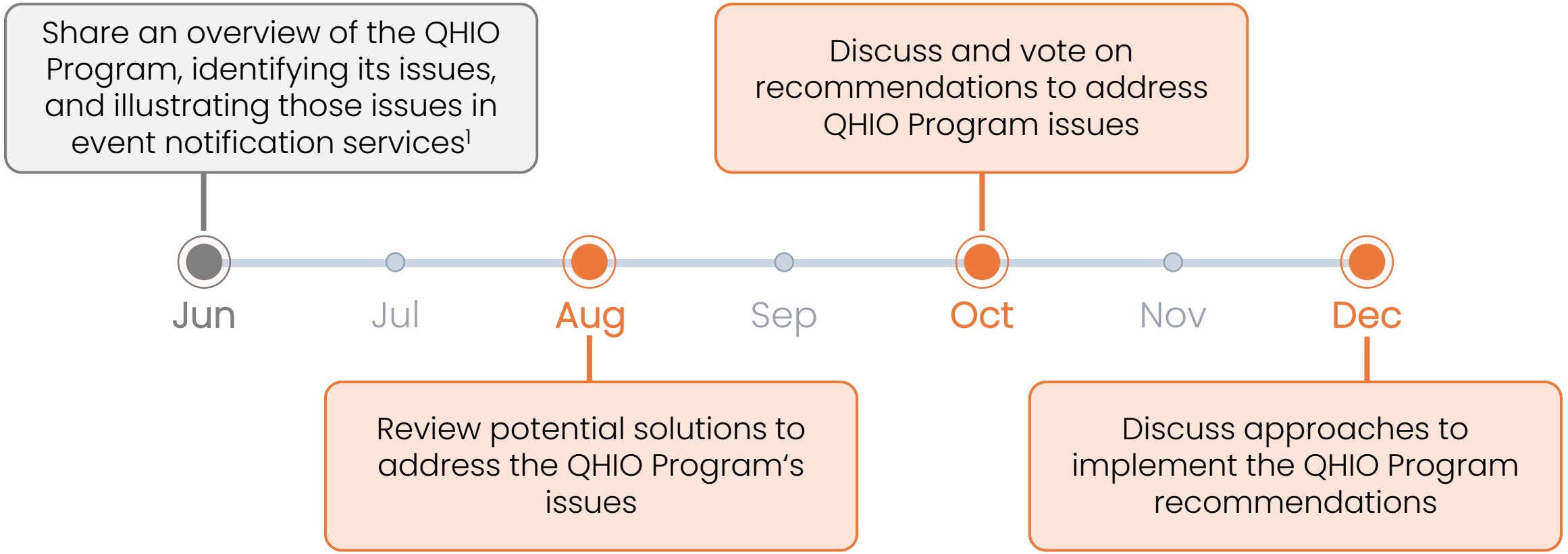
Jacob Parkinson, DxF Program Director
Robert M. Cothren, PhD, Data Exchange Framework Consultant

DATA EXCHANGE FRAMEWORK

HCAi Department of Health Care Access and Information

2026 Advisory Committee Meeting Roadmap

Between June and December, HCAI seeks Advisory Committee input and recommendations to strengthen the QHIO Program ("the Program").

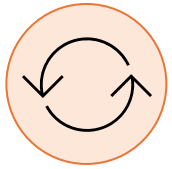


DATA EXCHANGE FRAMEWORK

HCAI Department of Health Care Access and Information

[1] *For Reference:* *June 18, 2026, Stakeholder Advisory Committee*

Today's Goals



Recap

QHIO Program issues introduced at the June meeting

Review

Approaches to address QHIO Program issues in other states and organizations

Describe

Actions HCAI plans to take to address some QHIO Program issues

Break

Discuss

Potential solutions that may address additional QHIO Program issues

DATA EXCHANGE FRAMEWORK

HCAI Department of Health Care Access and Information

Recap: Goals of the QHIO Program

Goal #1:
Support Statewide Exchange of HSSI

Goal #2:
Help Participants Meet DxF Requirements

DATA EXCHANGE FRAMEWORK

HCAI
Department of Health Care Access and Information

Recap: QHIO Issues Impacting Goals

Sustainability
QHIOs' sustainability concerns may be exacerbated by an attempt to support all DxF needs.

Goal #1 Goal #2

Service Gaps
Every QHIO does not serve all Participant types or provide all forms of exchange.

Goal #2

Reciprocity
Imbalance in the bidirectional exchange between QHIOs has prevented collaboration and statewide exchange.

Goal #1

Trust
Lack of trust due to privacy and security concerns has prevented collaboration and statewide exchange.

Goal #1

Voluntary Adoption
The technology-agnostic structure of the DxF has prevented comprehensive statewide exchange.

Goal #1 Goal #2

Oversight Limitations
Attestation-based oversight mechanisms has prevented full accountability in the Program.

Goal #1 Goal #2

To better understand these issues, HCAI conducted research into how other states have approached data exchange.

State Approaches

Architecture	Centralized	Distributed
	Description: Exchange is handled through a single, centralized service that supports all participants statewide. Examples: Maryland, Michigan, North Carolina	Description: Exchange is handled through multiple, cooperating entities. Examples: **California**, Massachusetts, New York, TEFCA

Use of Intermediaries	State Operated	HIOs and/or Commercial Vendors
	Description: Exchange services are provided by the state. Examples: North Carolina	Description: Exchange services are provided by intermediaries designated or hired by the state. Examples: **California**: QHIOs, Intermediaries, "self" Maryland: single commercial vendor Massachusetts: multiple commercial vendors Michigan: single state-designated HIE New York: state designated HIEs TEFCA: multiple QHINs

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State Approaches

	State Funded	Participant Funded
Funding	Description: State funds all services, including Medicaid federal financial participation. Examples: Maryland, Michigan, New York, North Carolina	Description: Services are supported through fees charged to organizations using services. Examples: California, Massachusetts, TEFCA

	State Mandated Exchange, Voluntary Use of Intermediaries	State Mandated Exchange, Mandatory Use of Intermediaries	Voluntary Participation, Mandatory Use of Intermediaries
Participation	Description: Participation in HIE is required by statute or regulation, use of state-designated intermediaries is voluntary. Examples: California	Description: Participation in HIE and use of centralized state services or state-designated intermediaries is required by statute or regulation. Examples: Maryland, Massachusetts, Michigan, New York, North Carolina	Description: Participation in HIE is voluntary, but participants must use a designated intermediary. Examples: TEFCA

QHIO Program Issue: Sustainability

Issue Summary

Meeting the diverse needs of DxF Participants is challenging due to differences in information needs, technology capabilities, and data types.

Program requirements may not always align with QHIO business models, and some Participants require services that QHIOs are not structured, funded, or technologically positioned to provide.

There is no consistent funding model to support the full range of Participant needs, creating a financing gap that limits what QHIOs can sustainably offer.

Addressing these varied needs requires significant investment, creating long-term sustainability risks for some QHIOs.

Other Approaches

North Carolina

- Offers a **single state-funded service**.

Maryland

- Contracted for and funded a **single state-procured service**.

Massachusetts & New York

- Established **qualification by exchange type** to allow an intermediary to focus on services it chooses to provide.
- Requires **hospital participation** to ensure qualified intermediaries are the sources of highly-valued events data.

Massachusetts

- Requires a **minimum operating threshold** for certification to further enable sustainability.

DATA EXCHANGE FRAMEWORK

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Note: *Reference DxF SAC Meeting #2 Slide Deck for full QHIO Program issue descriptions.*

QHIO Program Issue: Service Gaps

Issue Summary

Not every QHIO serves all Participant types or supports all forms of exchange.

QHIOs often focus their services on a subset of the participant community, limiting the availability of services for certain DxF Participants.

QHIOs may also focus on specific transaction types and may be hesitant to offer new services where there is not a consistent funding source to support them.

Some QHIOs serve dedicated regions while others operate statewide, creating territorial fragmentation and regional gaps.

As a result, some forms of exchange required by DxF receive limited support.

Other Approaches

Maryland, Massachusetts, Michigan & North Carolina

- Establish one or more vendors that cover all participants for each exchange type.

New York

- Transitioning from all qualified intermediaries providing all exchange types to specialization where some intermediaries offer different services for some exchange types.

TEFCA

- Requires all intermediaries to support its single exchange type for all participants.

DATA EXCHANGE FRAMEWORK

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Note: *Reference DxF SAC Meeting #2 Slide Deck for full QHIO Program issue descriptions.*

QHIO Program Issue: Reciprocity

Issue Summary

Not all QHIOs offer the same types of exchange (e.g., Request for Information, Information Delivery or Event Notification) **or volumes of exchange**, creating unequal burdens and benefits across QHIOs.

Market overlap and competition have increased scrutiny of the fairness of exchange between QHIOs and, in some cases, reduced willingness to collaborate.

Imbalance in the bidirectional exchange between QHIOs has prevented collaboration and statewide exchange.

Other Approaches

Maryland, Michigan & North Carolina

- Offer a **single service** which eliminates the demand for reciprocity.

Massachusetts

- Established a **minimum operating threshold** requirement to support reciprocity.

New York

- Established a statewide service **requiring all participating intermediaries to connect and share**.

Note: *Reference DxF SAC Meeting #2 Slide Deck for full QHIO Program issue descriptions.*

QHIO Program Issue: Trust

Issue Summary

QHIOs and their Participants rely on trust that data is requested and used for Permitted Purposes under the DSA and its P&Ps.

QHIOs have no explicit role in monitoring Participant activity, and there is no required reporting on data use, abnormal exchange patterns, or investigations.

Recent allegations of inappropriate access and data misuse have led some QHIOs to limit data exchange with one another.

Lack of trust and limited oversight have reduced collaboration and constrained statewide exchange.

Other Approaches

Maryland, Massachusetts & North Carolina

- All services are provided by the state or state-procured vendor with strong state oversight.
- State verifies participants.

TEFCA

- Intermediaries are responsible for vetting participants.
- Participants are required to include the purpose for use in each request for data.

DATA EXCHANGE FRAMEWORK

HCAI Department of Health Care Access and Information

Note: *Reference DxF SAC Meeting #2 Slide Deck for full QHIO Program issue descriptions.*

QHIO Program Issue: Voluntary Adoption

Issue Summary

Fragmented technology adoption may have resulted from the lack of a DxF requirement to use a specific technology. State law explicitly permits Participants may use any network, health information organization, or technology that complies with the DSA and its P&Ps.

Participants are not required to use a QHIO. The organizations that choose not to use a QHIO have excluded themselves from the statewide exchange network developed through the Program.

- ~25% of Participants are not choosing to use a QHIO or nationwide network; ~5-10% are labs and pharmacies.

Other Approaches

North Carolina

- **Legislative requirement** for providers receiving state funds to send data to the state services.

Massachusetts

- **Regulatory requirement** for hospital providers to participate in event services.
- Intermediaries offer flexible services for sending notifications but follow established standards for exchange with one another.

New York

- **Legislative requirement** for data sources to participate.

Michigan

- Promotes participation through **Pay-for-Performance** initiatives.

DATA EXCHANGE FRAMEWORK

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Note: Reference DxF SAC Meeting #2 Slide Deck for full QHIO Program issue descriptions. Utilization of QHIOs is drawn from responses in the Participant Directory.

QHIO Program Issue: Oversight Limitations

Issue Summary

Due to resource constraints, **the Program has relied primarily on attestations to verify QHIO compliance** with Program requirements, contributing to today's variability in capabilities and service levels.

The Program has often relied on the QHIOs to agree upon their own standards for exchanging with one another. However, disagreements in standard data sets and formats have often prevented meaningful collaboration and progress.

Attestation-based qualification mechanisms have prevented full accountability in the Program.

Other Approaches

Massachusetts

- The state establishes and monitors business, functional, security, privacy, and reporting standards for vendors.

Maryland, New York & North Carolina

- The statewide service **enforces a single set of standards**.

TEFCA

- QHIN-to-QHIN exchange **standards are documented**.
- Conformance with these **standards is tested** prior to qualification.

Note: *Reference DxF SAC Meeting #2 Slide Deck for full QHIO Program issue descriptions.*

Discussion of Other Approaches

- Sustainability
- Service Gaps
- Reciprocity
- Trust
- Voluntary Adoption
- Oversight Limitations

- Which of the approaches taken by other states or organizations appear to have the greatest potential for DxF?
- Are there any other approaches that should be considered?

Actions HCAI Plans to Take
Establish QHIO-to-QHIO Exchange Standards

Goal #1

Require all QHIOs to use specified data exchange standards for inter-QHIO exchange.

- Supports Statewide Exchange and minimizes Service Gaps by establishing and strengthening QHIO-to-QHIO exchange.
- Addresses Sustainability by establishing clear standards and common investments for all QHIOs.
- Addresses Oversight Limitations by specifying the data flows, triggers, and exchange standards all QHIOs must use with each other, reducing need for voluntary collaboration.

Improves coordination; reduces Program ambiguity and disagreements among QHIOs.

Reduces QHIO flexibility; may impede innovation if not implemented well.

Implementation: Implemented through regulations and QHIO Program modifications without impact to Participant P&Ps.

Application: Will address challenges with roster and event sharing for event notification services, creating opportunity for Participants to receive statewide notifications.

DATA EXCHANGE FRAMEWORK

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Actions HCAI Plans to Take
Voluntarily Exchange During Participant Verification

Goal #1 | **Goal #2**

Allow QHIOs (and other Participants) to suspend exchange of HSSI with signatories until Participant Verification determines they are legitimate health or social service organizations, governmental agencies, or vendors.

- Supports Statewide Exchange by increasing trust among QHIOs.
- Helps Participants meet their DxF obligations by increasing trust in the QHIO Program.
- Helps address Trust by providing greater transparency in verifying QHIO customers.

Improves trust in the QHIO Program and the security of the DxF.

Potentially complicates communicating and/or understanding the status of a Participant.

Implementation: Likely requires substantive amendment to the Requirement to Exchange P&P and changes to the Participant Verification Standards Operating Procedure.

Application: Potentially detects bad actors before they can inappropriately access or use health and social services information.

DATA EXCHANGE FRAMEWORK

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Note: *See Participant Verification for a description of the verification process.*

Public Comment

Break

Item #6

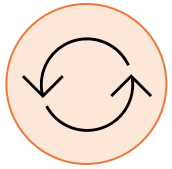
QHIO Program Evolution Part 2

Jacob Parkinson, DxF Program Director
Robert M. Cothren, PhD, Data Exchange Framework Consultant

DATA EXCHANGE FRAMEWORK

HCAI
Department of Health Care Access and Information

Today's Goals



Recap

QHIO Program issues introduced at the June meeting

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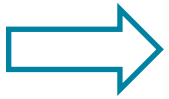
Approaches to address QHIO Program issues in other states and organizations

Describe

Actions HCAI plans to take to address some QHIO Program issues

Break

We are here



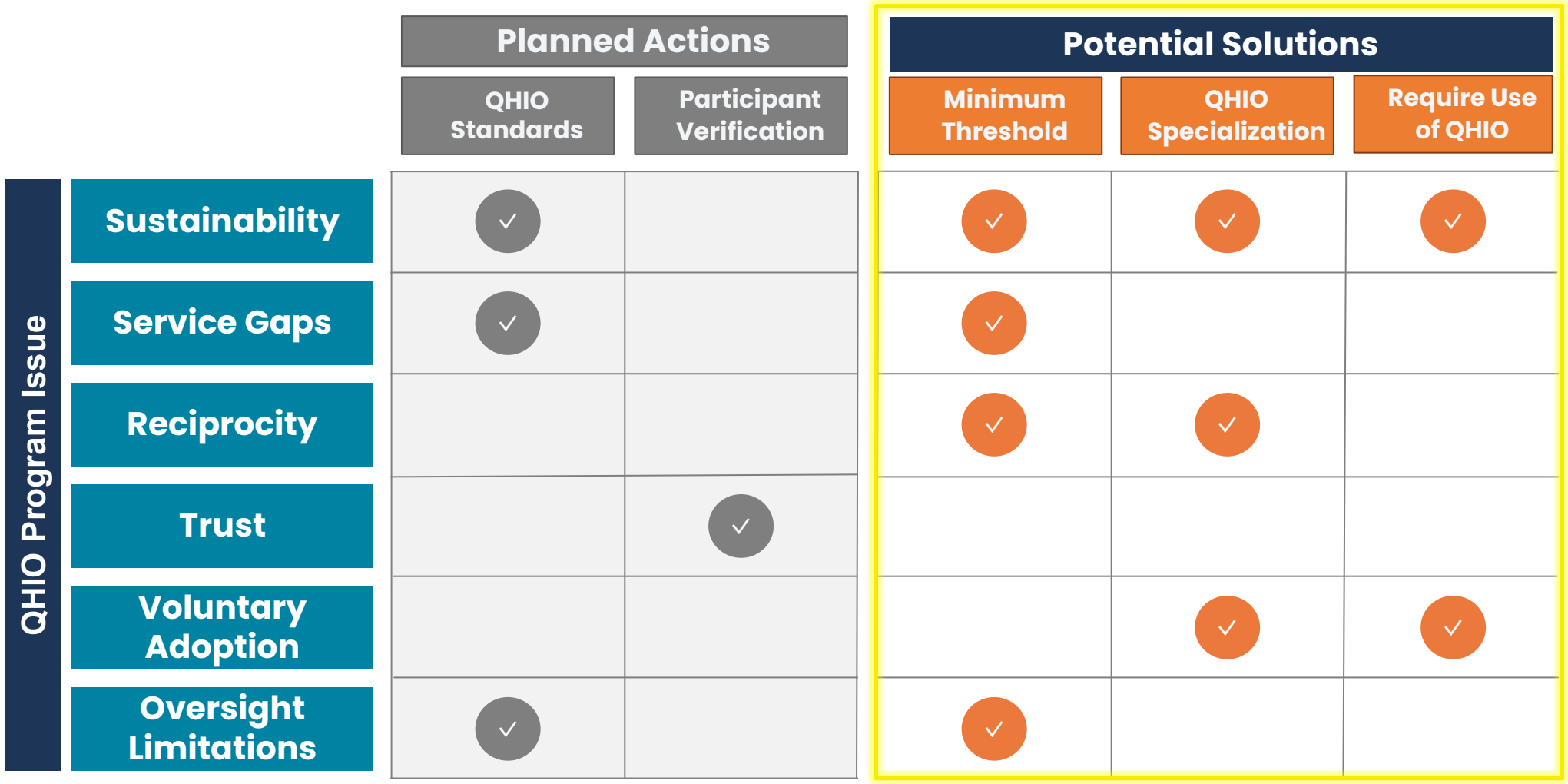
Discuss

Potential solutions that may address additional QHIO Program issues

DATA EXCHANGE FRAMEWORK

HCAI Department of Health Care Access and Information

Discussion of Potential Solutions



Potential Solution

Require Minimum Operating Threshold

Goal #1

QHIOs must demonstrate a minimum volume of existing business when seeking to qualify for an exchange type.

QHIO Issues Addressed

- Sustainability: QHIOs have already made the required investment and have existing business aligned with their business model/customer base.
- Service Gaps: QHIOs demonstrate existing service delivery with applicable Participants.
- Reciprocity: More equitable distribution of investment and revenue opportunities through demonstrated operating thresholds.
- Oversight Limitations: Clear evidence of capabilities through delivered services.

Pros

- Provides market-based evidence of capability.
- Reduces imbalance among QHIOs supporting the exchange type.
- Minimizes duplicative investments across the industry.

Cons

- More challenging for new or small organizations to qualify for an exchange type.
- Some existing QHIOs may no longer qualify for an exchange type.

DATA EXCHANGE FRAMEWORK

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Potential Solution

Require Minimum Operating Threshold

Options to Implement

- Can implement through revisions to QHIO Program.
- May require periodic re-qualification or terms.
- May require new application criteria for existing and new applicants.

Test Using Event Notification

- Ensures QHIOs qualifying for an exchange type can deliver the required services.
- Improves statewide exchange with QHIO focus on demonstrated service capabilities.
- Aligns services with existing business.

HCAI Perspectives

- Aligns with state trends (e.g., Maryland selection of an existing commercial service, Massachusetts minimum requirement of 20 or more acute care hospital customers).
- Improves upon the current attestation model for QHIO qualification.
- Achievable with modest effort for QHIOs, Participants, and the State; gains outweigh the effort required.
- Should improve Participant satisfaction in the QHIO Program.
- Accommodates a model in which QHIOs pay for receiving data for which they cannot reciprocate.

Potential Solution

Allow QHIOs to Specialize

Goal #1

QHIOs choose to support specific DxF exchange type(s) and seek qualification for these exchange type(s). Participants choose a QHIO that provides the services they need.

QHIO Issues Addressed

- Sustainability: QHIOs only need to make investments in the exchange types they offer and where they see a business rationale.
- Reciprocity: Leads to more equity in investment for QHIOs choosing a particular exchange type.
- Voluntary Adoption: Provides Participants with transparency into QHIO areas of focus.

Pros

- QHIOs invest in the services that align with their business model, avoiding expenses their customer base doesn't need and their business model doesn't support.
- QHIOs can focus on their strengths.

Cons

- Few QHIOs may choose to seek qualification for every exchange type, resulting in fewer QHIO options that meet all needs for some Participants.
- Some Participants may need to switch QHIOs or use more than one QHIO.

Potential Solution

Allow QHIOs to Specialize

Options to Implement

- Can implement through revisions to QHIO Program.
- May require new application criteria for existing and new applicants.
- Would require existing QHIOs to select exchange types for which they seek qualification.

Test Using Event Notification

- Aligns with prior DxF stakeholder recommendation for a QHIO network specializing in event notification.
- Improves statewide exchange as QHIOs focus on service strengths.
- Aligns services with existing business models.

HCAI Perspectives

- Aligns with several state trends (e.g., Maryland's one vendor, Massachusetts' two vendors, New York's shift away from equivalent services offered by all Qualified Entities to two that will specialize in events).
- Better aligns the QHIO Program and current/prospective QHIOs with DxF priorities.
- Achievable with modest effort for QHIOs, Participants, and the State; gains outweigh effort required.
- Likely to improve Participant satisfaction in the QHIO Program, may also lower costs.
- Contributes to more balanced, equitable program operations for QHIOs.
- Creates opportunity for other intermediaries - not currently qualified - to participate.

Potential Solutions

Require Minimum Operating Threshold & Allow QHIOs to Specialize

Discussion

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Potential Solutions

Require Minimum Operating Threshold & Allow QHIOs to Specialize

Public Comment

Potential Solutions

Require Minimum Operating Threshold

Fist-to-five poll to inform next steps in developing this potential solution


I don't support this approach


I have strong reservations, this approach needs revision


I am uncomfortable with this approach, but can live with it


I am okay with this this approach


I support this approach


I enthusiastically support this approach

DATA EXCHANGE FRAMEWORK

HCAI Department of Health Care Access and Information

Ex officio non-voting members may participate in the poll
Responses of all members will be recorded

Potential Solutions

Allow QHIOs to Specialize

Fist-to-five poll to inform next steps in developing this potential solution


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Potential Solution

Require Participant Use of QHIO Services

Goal #1

Require that Participants engaged in specific forms of exchange use QHIO services to break down silos, fill gaps in nationwide networks, and create greater efficiencies.

QHIO Issues Addressed

- Sustainability: Require use of QHIO services for specific exchange types, providing a more reliable customer base and revenue stream.
- Voluntary Adoption: Participants must contract with a QHIO offering the exchange service to share data with every other Participant.

Pros

- Participants are not required to make dedicated connections with Participants choosing 'Self'.
- Participants are not required to contract with multiple intermediaries to obtain statewide coverage for a single exchange type.
- A single connection results in statewide exchange.

Cons

- May require some Participants to contract with a QHIO that have not chosen to do so already.
- Limits choice for applicable exchange types.

Potential Solution

Require Participant Use of QHIO Services

Options to Implement

- May require legislative change to the statute
- May require a new application cycle to create opportunities for current service organizations.
- May require pricing guidelines.

Test Using Event Notification

- Aligns with prior DxF stakeholder recommendation for a QHIO network specializing in event notification.
- Enables statewide event notification through contracting with a single QHIO, reducing costs and complexity for Participants sending and receiving events.

HCAI Perspectives

- Aligns with state trends (e.g., North Carolina, Maryland, and Massachusetts require certain organizations to participate in selected services and/or with selected vendors; TEFCA requires use of a QHIN).
- May not be applicable for all exchange types, especially where nationwide networks exist.
- May not be appropriate for all Participants (e.g., labs and pharmacies don't necessarily need QHIOs).
- Will require time to implement legislative change and allow some Participants to adjust vendors.
- Provides a clear path to breaking down data silos to create statewide exchange.
- Satisfies a goal of many DxF Participants to work with a single entity to obtain statewide exchange.

Potential Solutions

Require Participant Use of QHIO Services

Discussion

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Potential Solutions

Require Participant Use of QHIO Services

Public Comment

Potential Solutions

Require Participant Use of QHIO Services

Fist-to-five poll to inform next steps in developing this potential solution


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Discussion of Other Potential Solutions

Allow QHIOs to Specialize

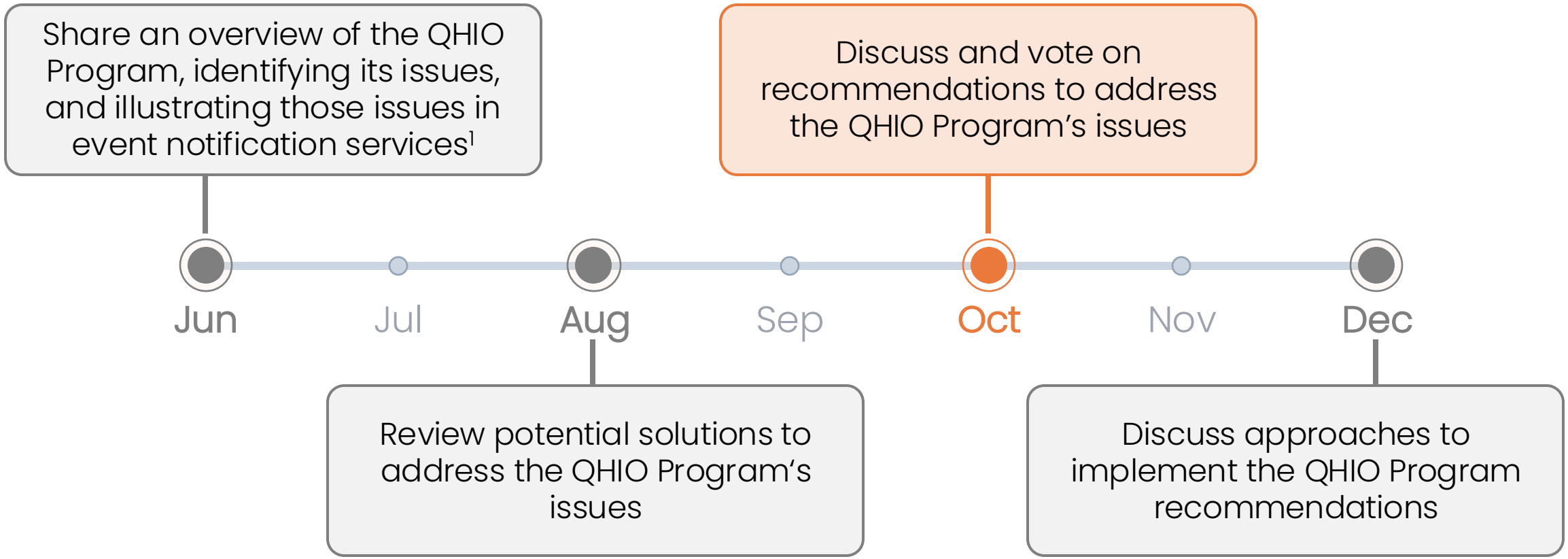
Require Minimum Operating Threshold

Require Participant Use of QHIO Services

- What other potential solutions should HCAI research and prepare for discussion at the October SAC meeting?

Public Comment

Reminder: October Discussion Topic



Item #7

General Public Comment

Jennifer Sayles, MD, MPH, Committee Chair

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Item #8

Closing Remarks & Adjournment

Jennifer Sayles, MD, MPH, Committee Chair

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Future Meeting Dates

Advisory Committee Meeting	Date	Time
In-Person Meeting # 4	October 15, 2026	10:00 am – 4:00 pm PT
In-Person Meeting # 5	December 17, 2026	10:00 am – 4:00 pm PT
In-Person Meeting # 6	February 18, 2027	10:00 am – 4:00 pm PT
In-Person Meeting # 7	April 15, 2027	10:00 am – 4:00 pm PT

Preliminary Meeting #4 Topics

- Public Accountability and Enforcement: Discuss Required Signatory Methodology and Accountability Approach
- QHIO Program Evolution: Continue Discussion and Vote on Solutions
- Collection of Individual Level Demographic and HRSN Data: Vote on Recommendations

Stay informed!

Add yourself to our mailing list for DxF updates.

dxf.chhs.ca.gov/stayinformed/

Department of Health Care Access and Information