**California Health & Human Services Agency**
**Center for Data Insights and Innovation**
**Data Exchange Framework Technical Advisory Subcommittee (TASC) Meeting**
**Transcript (1:00 PM – 2:00 PM PT, August 21, 2024)**

The following text is a transcript of the August 21, 2024 meeting of the California Health and Human Services Agency and Center for Data Insights and Innovation Data Exchange Framework TASC. The transcript was produced using Zoom's transcription feature. It should be reviewed concurrently with the recording – which may be found on the CalHHS Data Exchange Framework webpage to ensure accuracy.

[Alice K - Events] 16:01:11

Hello, and welcome!

[Alice K - Events] 16:01:12

My name is Alice, and I'll be in the background answering any zoom technical questions. If you experience difficulties during this session, please type your question into the Q. And a.

[Alice K - Events] 16:01:24

Individuals in the public audience who have a comment may insert it into the Zoom. Q, and a.

[Alice K - Events] 16:01:29

Public comment will also be taken towards the end of the meeting.

[Alice K - Events] 16:01:32

Live closed captioning will be available. Please click on the CC. Button to enable or disable. And with that I'd like to introduce room.

[Rim Cothren] 16:01:42

Thank you. Alice.

[Rim Cothren] 16:01:43

Hopefully, you can hear me. Okay.

[Rim Cothren] 16:01:47

I'm Rim Catherine, and thanks everyone for joining us for this task series. It's been a little while since task has met, and I hope that everyone has had a good short break.

[Rim Cothren] 16:02:00

This series planned for 2 meetings.

[Rim Cothren] 16:02:03

We're going to be taking a look specifically at the exchange of sensitive data.

[Rim Cothren] 16:02:10

I wanna remind the task members. We encourage everybody to turn their video on. This is meant to be a discussion, not a bunch of presentations. So really, encourage people to get engaged.

[Rim Cothren] 16:02:23

Also, if you do use the chat, please be sure to chat to everyone. I know that several people have been on chat.

[Rim Cothren] 16:02:30

Before the meeting started.

[Rim Cothren] 16:02:33

With some local conversations.

[Rim Cothren] 16:02:35

Let's go on to the next slide. Please.

[Rim Cothren] 16:02:39

Just real quickly. The vision for the data exchange is something that we always open all of our meetings with.

[Rim Cothren] 16:02:45

The intent here is to create new connections and efficiencies between health and social service providers.

[Rim Cothren] 16:02:52

To improve whole person care. Today's.

[Rim Cothren] 16:02:54

And our next meetings topics are on a specific topic of health information that we wanna talk about some of the barriers and opportunities to protect sensitive information on the Dxf.

[Rim Cothren] 16:03:10

Let's go on to the next slide. Please.

[Rim Cothren] 16:03:13

Our agenda very briefly. What we're doing now.

[Rim Cothren] 16:03:17

We'll have a couple of short presentations.

[Rim Cothren] 16:03:22

On some prepared material to help.

[Rim Cothren] 16:03:26

Provide some background information for folks about half the meeting we've got set aside, really to do general discussions. We will have a public comment period currently scheduled at 10 min before the hour we try to hit that mark pretty pretty rigidly, and then very short next steps and closing remarks.

[Rim Cothren] 16:03:48

Next slide, please.

[Rim Cothren] 16:03:52

Just as a reminder. This is a public meeting, and we are going to provide.

[Rim Cothren] 16:03:56

Opportunities for the public to make comments.

[Rim Cothren] 16:03:59

1st we will take public comment.

[Rim Cothren] 16:04:02

During the meeting at approximately 10 till the hour.

[Rim Cothren] 16:04:07

As listed on the agenda, and we'll be limiting the total amount of time to that that's allocated there. Members of the public are also welcome to use Zoom's.

[Rim Cothren] 16:04:17

QA. Feature to ask questions or make comments during the meeting, and, as always, can make.

[Rim Cothren] 16:04:24

Can also email their questions or comments to the address listed here. That's dxf@chca.gov.

[Rim Cothren] 16:04:35

Next slide, please.

[Rim Cothren] 16:04:38

Let's roll through. Roll! Call real quickly. I'm Catherine, and I'm here, Cindy. I saw that you were on as well. Hans, are you here?

[Hans Buitendijk] 16:04:47

Yes. Good afternoon.

[Rim Cothren] 16:04:48

Thanks. Hans.

[Rim Cothren] 16:04:50

Cassian.

[Cassie-Ann Bush] 16:04:52

Cassie's here.

[Rim Cothren] 16:04:53

Thank you. Sarah.

[Rim Cothren] 16:04:56

Didn't hear from Sarah Mohit.

[Rim Cothren] 16:05:02

Didn't hear from Mohit.

[Rim Cothren] 16:05:03

Prashan.

[Rim Cothren] 16:05:07

Didn't hear from.

[Rim Cothren] 16:05:09

Prashant, John.

[John Helvey] 16:05:11

Yes, sir.

[Rim Cothren] 16:05:13

You don't have to call me Sir John.

[Rim Cothren] 16:05:16

Cameron.

[Rim Cothren] 16:05:20

Cameron is a new member to the task. I didn't hear from Cameron Kimberly.

[Rim Cothren] 16:05:28

Didn't hear from Kimberly.

[Rim Cothren] 16:05:31

Michael.

[Rim Cothren] 16:05:33

Pretty sure Michael is out of office. I I'm pretty sure that I saw a note from him.

[Rim Cothren] 16:05:38

Chris.

[Chris Muir] 16:05:39

Yes, here.

[Rim Cothren] 16:05:40

Thank you, Chris.

[Ken Riomales] 16:05:42

Good afternoon.

[Rim Cothren] 16:05:44

Thanks. Ken jess.

[Rim Cothren] 16:05:49

Didn't hear from Jess Hanon.

[Rim Cothren] 16:05:54

Didn't hear from Hanan. Joe.

[Rim Cothren] 16:05:58

Thanks. Joe and Brian.

[Rim Cothren] 16:06:01

Thanks, Brian, and then we have 5 folks that are joining us for this meeting series like to give them just a second to introduce themselves.

[Rim Cothren] 16:06:11

Dr. Jafari.

[Rim Cothren] 16:06:16

Just say Hello! Your name, and where you're from.

[Mohammad Jafari] 16:06:17

Am I audible? Thank you.

[Mohammad Jafari] 16:06:18

Yeah. Hello.

[Mohammad Jafari] 16:06:20

Yeah. So I'm Mohammed. I am from a joint faculty of Arizona State University. I'm also the coacher of Hl. 7. Community based and privacy and also human and social services.

[Rim Cothren] 16:06:33

Thank you. Mohammed. Dr. Lane.

[Steven Lane] 16:06:35

I'm Steven Lane. I'm a clinical informaticist. I support a number of.

[Steven Lane] 16:06:42

Companies in the interoperability space particularly health, which is serving as a Qio.

[Steven Lane] 16:06:49

On the date exchange framework, and also on.

[Steven Lane] 16:06:52

Faculty at Ucsf. And Stanford, and a practicing family physician.

[Rim Cothren] 16:06:57

Thanks, Steven Kelvin. Are you out there?

[Kelby Lind] 16:07:01

Yes, I am. Good afternoon.

[Rim Cothren] 16:07:06

Lisa mates.

[Rim Cothren] 16:07:13

Didn't hear from Lisa. Maybe she'll be joining us late.

[Rim Cothren] 16:07:16

And Dr. Rui.

[Raymonde Uy] 16:07:18

Yes, good afternoon, everyone. My name is Dr. Raymond. I'm a physician from Madison with the National Association of Community Health Centers.

[Raymonde Uy] 16:07:26

I handle clinical terminology and data, normalization and quality for Cdc and public health grants and research. Thanks for having me.

[Rim Cothren] 16:07:35

Thank you, Ray.

[Rim Cothren] 16:07:36

It's gone to the next slide. Please.

[Rim Cothren] 16:07:41

Just real quickly. Our objective for the series, 3 meetings of the task will be to center on discussing the technical and operational challenges.

[Rim Cothren] 16:07:51

A protect protecting, reproductive and gender information under the Dxf.

[Rim Cothren] 16:07:57

To comply with Ab. 3, 52, and explore opportunities to address these challenges. We're not really looking for solutions here so much.

[Rim Cothren] 16:08:05

As to understand what the barriers are, and perhaps some approaches to addressing those barriers. This is going to be a short meeting series. We're only planning on 2 meetings today and another meeting. In 2 weeks we'll be asking our guests to are inviting our guests to join us for the next meeting as well.

[Rim Cothren] 16:08:23

Let's go on to the next slide. Please.

[Rim Cothren] 16:08:27

And the next slide.

[Rim Cothren] 16:08:29

So this one is for me I just wanted. I'm not gonna read this text, but I wanted to pause here for a minute, and just

[Rim Cothren] 16:08:38

Help, clarify.

[Rim Cothren] 16:08:40

What A, B, 3, 52 actually requires in statute for the protection.

[Rim Cothren] 16:08:46

Of abortion, related services, gender care.

[Rim Cothren] 16:08:55

Folks should have hopefully received this information. Prior the slide deck, prior to.

[Rim Cothren] 16:09:02

The meeting, and

[Rim Cothren] 16:09:06

May should have had a chance to review the the language that's in A B.

[Rim Cothren] 16:09:11

3, 52. During that time.

[Rim Cothren] 16:09:14

What we did not put on this slide. But just to remind people is that Ab 3 also amended.

[Rim Cothren] 16:09:21

Health and safety code.

[Rim Cothren] 16:09:23

1, 3, 0, 2, 9. 0, that creates the data! Exchange framework.

[Rim Cothren] 16:09:27

An added section B, 3. That the requirement to provide access to in exchange of health information in real time shall not apply to the exchange of health information related to abortion, abortion related services.

[Rim Cothren] 16:09:39

So anybody that goes out to the statute there will see that that has been added as an amendment to that regulation. As a result of Ab, 3, and also created some changes.

[Rim Cothren] 16:09:53

To the data, exchange framework policies and procedures to help.

[Rim Cothren] 16:09:58

Our participants. Comply with that regulation.

[Rim Cothren] 16:10:03

Let's go on to the next slide. Please.

[Rim Cothren] 16:10:10

And, Steven, I will turn things over to you to kick us off with this presentation.

[Steven Lane] 16:10:14

Great. Thank you so much, RAM, and it's great to be here in this context. Mohammed Ray and I have had a chance to discuss this in in a number of different settings, and through my ongoing engagement with data exchange framework. You know it. It has been clear that there has been a need to dive into this area to figure out how.

[Steven Lane] 16:10:39

You know the dxf participants, etc.

[Steven Lane] 16:10:43

Are going to successfully manage this in this sensitive information, as it moves across the system.

[Steven Lane] 16:10:50

So again, Mohammed and and Ray of each introduced themselves. They really are the experts in this space, Mohammed, in terms of the technical underpinning of how we can tag data, right rules manage data. What is the latest technical opportunities that we have and the standards that are out there, most of which have really never been exercised at scale.

[Steven Lane] 16:11:15

And Ray has really come forward over the past year. So as a subject matter, expert in terms of developing the value sets that are needed.

[Steven Lane] 16:11:25

To identify sensitive data that can then be managed appropriately. So I'm gonna quickly turn it over to them and thank you again for the opportunity for us to speak with the group.

[Raymonde Uy] 16:11:36

I'll start, I guess. By teing up Dr. Jafari here on the data segmentation piece.

[Raymonde Uy] 16:11:43

For those who are not aware. There is an H. 7 standard called DS. 4, P. Or data segmentation for privacy.

[Raymonde Uy] 16:11:51

Which is applicable in Cdas or clinical. The CD. Or clinical documentaries.

[Raymonde Uy] 16:11:57

Which includes the data segmentation for privacy, electronic labeling, or tagging of patient health information.

[Raymonde Uy] 16:12:04

And I'll let Mohammed speak more on the contents. Kind of some specifics in general that people need to know when discussing and looking at Ab. 3, 52. Mohammed.

[Mohammad Jafari] 16:12:14

Thank you. So as as Raymond mentioned, so you know, we do have the standards for recording tables, both in a documents and for fire. This has been well documented, and there's specifications that are relatively mature out there.

[Mohammad Jafari] 16:12:32

There. There are some gaps as we're discussing the challenges here on how to record. What labels to use. We have a set of sensitivity labels in each of them, terminology that's been discussed.

[Mohammad Jafari] 16:12:45

But some of those values are not as granular or as recent.

[Mohammad Jafari] 16:12:51

And you know, we, I think we need specific labels for these particular use cases for reproductive health and and these emerging use cases that that has been.

[Mohammad Jafari] 16:13:00

Basically stop tricking attention in the past couple of years. So that's 1 of the areas of challenges.

[Mohammad Jafari] 16:13:04

The other area of challenge is the value that the clinical values that would actually imply.

[Mohammad Jafari] 16:13:10

The application of those rules and those tags.

[Mohammad Jafari] 16:13:14

And I I think that's something that's been worked on. And and I'm pretty sure there's going to be more conversation about that later today.

[Mohammad Jafari] 16:13:22

And the 3rd piece, that is a little bit of a challenge still is the interface that some of the standard interfaces for Api.

[Mohammad Jafari] 16:13:31

And and programmatic implication of the Data Segmentation Service. So I I.

[Mohammad Jafari] 16:13:39

To. To sum it up, basically, I want to say that we do have some of the standard covering some of the technical space that that we need to leverage here. But then there's also some missing pieces that that's being worked on, and and should kind of mature in the same project.

[Mohammad Jafari] 16:13:57

There's been also some reference implementations and demonstration kind of quality software that's out there.

[Mohammad Jafari] 16:14:04

That came out of the Onc lead project.

[Mohammad Jafari] 16:14:08

So you know that that's sort of like the state of the affairs when it comes to technical.

[Mohammad Jafari] 16:14:15

Underpinnings here.

[Mohammad Jafari] 16:14:19

I yield back, Raymond, to you.

[Raymonde Uy] 16:14:21

Yes, thank you. Dr. Jafari again. What Dr. Is mentioning.

[Raymonde Uy] 16:14:26

Is that there is a way to add tags on specific documents.

[Raymonde Uy] 16:14:32

So our Cda documents, right documents complied with Cda or the clinical document.

[Raymonde Uy] 16:14:39

And there are value sets that.

[Raymonde Uy] 16:14:42

Do tag these documents, and then you seeing it on the the very basic tags on the chat. Here, example, codes would include unrestricted, low, moderate, normal, restricted, very restricted.

[Raymonde Uy] 16:14:53

The big issue that we are seeing is that adoption for these kinds of.

[Raymonde Uy] 16:14:59

Data, sharing document, sharing or release.

[Raymonde Uy] 16:15:03

Is high for document level, tagging, but not section level, tagging.

[Raymonde Uy] 16:15:08

But we can go talk about that some other time. But what I want to kind of show here is.

[Raymonde Uy] 16:15:13

What we have been doing on the value set space. So which helps identify different codes or different.

[Raymonde Uy] 16:15:21

Records that may or may not have the the codes in these concepts.

[Raymonde Uy] 16:15:27

As a reminder.

[Raymonde Uy] 16:15:29

On what CAB, 3, 52 does on the left hand side, starting in July the 1st 2,024. That business store and maintain medical information, must develop capabilities to segregate and protect.

[Raymonde Uy] 16:15:41

This information, specifically related to number one, gender. Contraception, 3. Abortion abortion related services. Those 3.

[Raymonde Uy] 16:15:50

Examples in the chat that you've seen earlier. That is kind of is very similar to this kind of work is.

[Raymonde Uy] 16:15:56

Confidentiality and security and sensitivity in Ds. 4 piece for peace, such as HIV.

[Raymonde Uy] 16:16:03

Sickle, cell substance, abuse, mental health and genetic conditions that are not.

[Raymonde Uy] 16:16:07

Reportable under the regular hipaa privacy rule.

[Raymonde Uy] 16:16:11

Just a reminder for everyone. The hipaa privacy rule permits disclosure of health records without.

[Raymonde Uy] 16:16:18

Explicit patient authorization for specific purposes.

[Raymonde Uy] 16:16:21

These are 2 general specific purposes. One is public health activities, and number 2 is law enforcement purposes. Again, they don't need in general.

[Raymonde Uy] 16:16:30

Patient authorization for those 2 purposes.

[Raymonde Uy] 16:16:34

And it leaves it to the state.

[Raymonde Uy] 16:16:35

To help create these rules on specific domains, such as again, in this case, for productive health.

[Raymonde Uy] 16:16:43

Right.

[Raymonde Uy] 16:16:43

So moving forward.

[Raymonde Uy] 16:16:46

Here the on the middle. Here you're seeing providers. Plans may not knowingly share information related to these 3 outside of the State of California without.

[Raymonde Uy] 16:16:56

Authorization from the patients.

[Raymonde Uy] 16:16:59

Or the holders of the data. This began last January 1, st 24.

[Raymonde Uy] 16:17:03

And for the x.

[Raymonde Uy] 16:17:05

For the Dig exchange framework participants. They're really not required to share health information related to these as part of the data exchange framework.

[Raymonde Uy] 16:17:15

So what you're seeing here are value sets that have been created or completed and have been uploaded on Vsac or the value set authority center for those who do are not familiar with Vsac.

[Raymonde Uy] 16:17:26

Vsac is the National Library of Medicine, sponsored platform for uploading value sets for those who don't know what value sets are.

[Raymonde Uy] 16:17:36

Value sets are basically a list of codes from different reference terminologies or standard terminology, such as Icd tents, nomad ct, flowing arc.

[Raymonde Uy] 16:17:45

You name it. We can create value sets for that as it's supported on Vsac.

[Raymonde Uy] 16:17:50

You will need a new Mls license to free umls license to access.

[Raymonde Uy] 16:17:55

And all of these value sets you're seeing in the next couple of slides have been published there under the Naac stewardship and Achc.

[Raymonde Uy] 16:18:02

So what you're seeing here is applies to California, A, B, 3. If it's those who are also thinking about Maryland, Maryland, and also the Ocr hipaa, privacy rule.

[Raymonde Uy] 16:18:14

Which is.

[Raymonde Uy] 16:18:16

Does not really specify.

[Raymonde Uy] 16:18:18

With the wording, or the.

[Raymonde Uy] 16:18:21

How do you say this?

[Raymonde Uy] 16:18:21

The formal definitions of what.

[Raymonde Uy] 16:18:25

Is in scope of quote, unquote, reproductive healthcare.

[Raymonde Uy] 16:18:28

Fortunately.

[Raymonde Uy] 16:18:29

For a b, 3.

[Raymonde Uy] 16:18:30

3, 52. It. It does specify abortion, services, gender care and contraception.

[Raymonde Uy] 16:18:36

There is an overlap.

[Raymonde Uy] 16:18:38

With the Ocr. Again, privacy rule, which is abortion and contraception.

[Raymonde Uy] 16:18:43

The Ocr hipaa. Privacy rule does not include gender.

[Raymonde Uy] 16:18:46

So on the left hand side you're seeing these are again. These are all models. These are on vac.

[Raymonde Uy] 16:18:52

Starting from the top, left abortion medications. Metrics was previously used.

[Raymonde Uy] 16:18:56

Long time ago. And abortion that's not being used so much anymore, if not.

[Raymonde Uy] 16:19:01

That's not being used.

[Raymonde Uy] 16:19:02

And are the very popular myth, stone and misoprostal, and their different brand names and different formulations and compounds.

[Raymonde Uy] 16:19:08

So if you look at the value set and checked it out on Vsa, you will see all.

[Raymonde Uy] 16:19:14

Myth or stone and myth missile, prostall.

[Raymonde Uy] 16:19:17

Medications that are available in the United States, both in Arx, norm and ndc.

[Raymonde Uy] 16:19:22

Codes, which means it has the brand names, regardless of those or those form.

[Raymonde Uy] 16:19:29

As long as it is.

[Raymonde Uy] 16:19:30

Using the generic Miso star mafia in any forms or purposes. Those have been built.

[Raymonde Uy] 16:19:35

Next would be abortion. And you're seeing a comma here for all there is a grouper that includes all of these value sets. Again. You can have a value set which groups different value set. So a grouper of groupers.

[Raymonde Uy] 16:19:47

And this have this have been this. These have been built. You're seeing that trimester trimester based abortion.

[Raymonde Uy] 16:19:56

Has been built.

[Raymonde Uy] 16:19:57

As well.

[Raymonde Uy] 16:19:59

As you know, some people or some States do specify which trimesters, or which how many weeks it is allowable, or legal or legal.

[Raymonde Uy] 16:20:08

There also have been value sets produced for different types of abortions, and we know that there is some misinformation in the public or just lack of information on the types of abortion, or what is included from the medical or clinical context.

[Raymonde Uy] 16:20:24

We know that there are spontaneous abortions. It is called an abortion, but.

[Raymonde Uy] 16:20:29

As most colloquially. People colloquially know them as miscarriages.

[Raymonde Uy] 16:20:32

There are also codes that includes or represents, failed attempts, abortion and induced abortion.

[Raymonde Uy] 16:20:41

You will see that the elective abortions very, very small or very, very short. I think there's 2 or 3 codes only, for that does semantically.

[Raymonde Uy] 16:20:50

Show that something was, in fact.

[Raymonde Uy] 16:20:53

We also know that there are 2 types of management for abortion. One is medical management, and one is surgical management. The procedure codes, and all related codes related to these concepts are also been uploaded on Vsac.

[Raymonde Uy] 16:21:05

On the right hand side also. Age of, we know, is very, very important, especially from the obstetric care. All Obg. What ends need this information. This can be approximated by different in different ways.

[Raymonde Uy] 16:21:18

But this is a very, very important data element that have been built also. So if you're trying to find age of the station and databases, or protect that information. Then you can use that value. Set.

[Raymonde Uy] 16:21:28

For gender farming care. Specifically, again, this is included in California, Ab. 3, 2.

[Raymonde Uy] 16:21:33

Gender orientation, sexual or sexual orientation are harmonized with us. Cdi version 3.

[Raymonde Uy] 16:21:40

Which is mandated.

[Raymonde Uy] 16:21:41

And for use for certified health, it products under the aspiri. One final rule.

[Raymonde Uy] 16:21:48

So you can use those just to use this to kind of segment or kind of look at your data and stratify them.

[Raymonde Uy] 16:21:55

Gender dysphoria quote unquote, is also has also been built.

[Raymonde Uy] 16:21:58

But this does not include Dsm. 5. Codes or anything related. This uses icd. 10 codes and the snowman Ctes that do encompass the concept of gender dysphoria.

[Raymonde Uy] 16:22:10

For intersex surgery. You're seeing a comma and all here, which includes all of the intersexory value sets that you're seeing.

[Raymonde Uy] 16:22:17

Female, to male, male, to female.

[Raymonde Uy] 16:22:20

History of intersex surgery which goes to the past medical history and intersex surgery nonspecific, but because there are codes that do not specify the directionality, or what kind of intersexury is happening.

[Raymonde Uy] 16:22:34

For transfemin regimens. Again, these are for these regiments. They're transfeminent and trans masculine.

[Raymonde Uy] 16:22:40

For a transformative regim.

[Raymonde Uy] 16:22:44

We have built.

[Raymonde Uy] 16:22:46

Anti androgens, estrogens and gnrage agonists. These are the type the pharmacologic classes of drugs that are being used by.

[Raymonde Uy] 16:22:54

Physicians that are doing transfemin care.

[Raymonde Uy] 16:22:57

Similarly, for trans masculine care.

[Raymonde Uy] 16:23:01

This parental parental testosterone or injectable testosterone and transfer have been built here on these value sets. So I welcome everyone to take a look.

[Raymonde Uy] 16:23:09

If you have a special specialist, or some specialty that does.

[Raymonde Uy] 16:23:14

Do these kinds of, or does collect these kinds of information, please have them look at them so that we can kind of improve them.

[Raymonde Uy] 16:23:20

All of these were built based on the latest clinical practice guidelines from the associated societies that.

[Raymonde Uy] 16:23:26

A lot of physicians follow, so please invite everyone. Take a look.

[Raymonde Uy] 16:23:31

Next. Here is contraception again, very big. Build out.

[Raymonde Uy] 16:23:36

This applies for both California, Ab. 52, and the Ocr hipaa privacy rule.

[Raymonde Uy] 16:23:40

Contraception at the top left here include counseling and surveillance. So for those interested in looking at.

[Raymonde Uy] 16:23:46

Postpartum, contraceptive counseling, for example, or.

[Raymonde Uy] 16:23:50

Surveillance of contraception. They check to see if the iod is still in place. Stuff like that. There are specific procedure and billing codes that are related to those.

[Raymonde Uy] 16:23:58

For the overarching or parent category here, which includes contraceptives. All.

[Raymonde Uy] 16:24:03

We have built all of these value sets which includes all contraceptives available in the market in the United States.

[Raymonde Uy] 16:24:13

Both in Ndc. Or national drug classification codes and Rxn. Rxn. Being the terminology or reference standard.

[Raymonde Uy] 16:24:21

That.

[Raymonde Uy] 16:24:22

A asp bureau and see it does have.

[Raymonde Uy] 16:24:25

Mentioned as a way to represent drugs.

[Raymonde Uy] 16:24:28

And Usdi version 3. Again, Rxn. And or and and DC. Codes.

[Raymonde Uy] 16:24:33

On the top. Here again Lark.

[Raymonde Uy] 16:24:36

Contraceptive implants and iuds Ied specifically have been broken down into 3.

[Raymonde Uy] 16:24:41

A hormonal based Iud copper.

[Raymonde Uy] 16:24:43

I uds and iuds that codes that do not have a specific. This does not specify either. If it's hormone or copper.

[Raymonde Uy] 16:24:52

Oral contraceptives. There is a group or Co value set for that as well, which includes cocs and pops.

[Raymonde Uy] 16:25:00

Or Co. Combination, or conceptives per destination, or progesters, and only pills.

[Raymonde Uy] 16:25:06

Emergency contraception. I wanted to note this because emergency there is a specific dose.

[Raymonde Uy] 16:25:12

Those strengths that goes in the use of Ec or emergency contraception. You don't have to buy Plan B, you can actually combine oral contraceptives to get to that. Those.

[Raymonde Uy] 16:25:23

Strength, that that it becomes an easy.

[Raymonde Uy] 16:25:25

And we have included generic combinations or representations of that. Those strength for this value set.

[Raymonde Uy] 16:25:32

And all conceptives that are through our use.

[Raymonde Uy] 16:25:35

A few more here. Contraceptive. We know it. Sterilization is, in fact.

[Raymonde Uy] 16:25:40

Contracept! A method of contraception, right.

[Raymonde Uy] 16:25:43

Both male and male and female, contraception.

[Raymonde Uy] 16:25:46

In terms of sterilization have been including and have been built out. Mail, including, for example, vasectomies. Female would include, for example,

[Raymonde Uy] 16:25:54

What we call, for example, bilateral.

[Raymonde Uy] 16:25:59

Of your Philippian tubes, for example, that.

[Raymonde Uy] 16:26:01

For those next last one here, this not as use as much, but poic's.

[Raymonde Uy] 16:26:08

Or progester only injectable contraceptions, transdermal patches.

[Raymonde Uy] 16:26:13

Rings, cervical barriers.

[Raymonde Uy] 16:26:15

Diaphragms and cervical caps, which is kind of the method of of preventing pregnancies.

[Raymonde Uy] 16:26:21

Female and or male condom use spermicides and sponges. Again, those have all been built.

[Raymonde Uy] 16:26:27

And it. This is the best, and and.

[Raymonde Uy] 16:26:30

We really worked hard on creating these value set. So please take a look if you see any codes that are missing, or if it isn't complete. Please let us know.

[Raymonde Uy] 16:26:38

But what we are updating this on the cycle of the reference terminology updates.

[Raymonde Uy] 16:26:42

For infertility. These are not explicitly included in California, Ab. 3, 2, but overarchingly for the Ocr hipaa privacy rule. This is stated so if you are interested in looking at those.

[Raymonde Uy] 16:26:55

Infertility. Codes for female, and males, and infertility and female medications have also been included for those who have experience or have knowledge in Ivf.

[Raymonde Uy] 16:27:06

These are usually used.

[Raymonde Uy] 16:27:08

But more needs to be developed because infertility is very tricky. And unfortunately, I'm not the fertility, doctor.

[Raymonde Uy] 16:27:15

Miscarriage. Management is the wording used in the legalese.

[Raymonde Uy] 16:27:19

Which.

[Raymonde Uy] 16:27:21

Specifies.

[Raymonde Uy] 16:27:22

Wording. Where those.

[Raymonde Uy] 16:27:24

That these codes, or they should have an ability to identify those who have had a miscarriage. Again, these are the legal wordings on the bill.

[Raymonde Uy] 16:27:34

That translates, to which value set that you can see on Vsac.

[Raymonde Uy] 16:27:36

Again, these should be in combine in combination with the codes included, for example, and Mr. Prostal, not everyone who have misoprostone in their medical record, have had an abortion. These are.

[Raymonde Uy] 16:27:51

Medications, Used.

[Raymonde Uy] 16:27:53

For other management of other obstetric and gynecologic.

[Raymonde Uy] 16:27:56

Issues. And that's what I think sometimes is lost. And for a lot of people.

[Raymonde Uy] 16:28:03

Last but not least, prenatal care.

[Raymonde Uy] 16:28:05

As stated there in the legalese. Again, that there should be a way to confirm that the pregnant patient is pregnant.

[Raymonde Uy] 16:28:12

And that allows these patients to be within what's called the prenatal visit windows prior to delivery. We know that we don't.

[Raymonde Uy] 16:28:20

Physicians don't trust a patient when they say they're pregnant. This always has to be confirmed using a pregnancy test, either a urine or or a blood serum or plasma test.

[Raymonde Uy] 16:28:30

Surrogate data elements. You're seeing here that allow a notification of pregnant women within the prenatal period.

[Raymonde Uy] 16:28:36

Patients with an estimated date.

[Raymonde Uy] 16:28:40

Recorded in their record, or allow, or an Lmp.

[Raymonde Uy] 16:28:43

Or less menstrual period element.

[Raymonde Uy] 16:28:46

Last 3. Here prenatal encounters includes prenatal supervision or visits.

[Raymonde Uy] 16:28:52

These are tricky because the these prenatal encounters are usually represented using a billing code which is in combination with other prenatal management.

[Raymonde Uy] 16:29:01

Emm codes.

[Raymonde Uy] 16:29:04

Encounters with those mark the end of the prenatal period due to delivery.

[Raymonde Uy] 16:29:09

There's a value set.

[Raymonde Uy] 16:29:10

Which encapsulates this concept called pregnancy, ending and delivery.

[Raymonde Uy] 16:29:14

Last but not least, data elements for patients currently pregnant with or without confirmatory lab tests with these are value sets that.

[Raymonde Uy] 16:29:23

Do, in fact, represent the concept of pregnancy, but these are confirmed using imaging or ultrasound, for example, those with codes for multiple gestation, and those are included in the pregnancy. All value set.

[Raymonde Uy] 16:29:35

So again, any issues with these sets, please let me know. I will. Happy to support.

[Rim Cothren] 16:29:41

Thanks, ray.

[Rim Cothren] 16:29:43

I.

[Rim Cothren] 16:29:43

I know that we've taken a fair amount of time here already, but I do wanna pause here for a second just to see if there are any specific questions for Ray Mohammed or Steven here.

[Rim Cothren] 16:29:53

I would also encourage everybody to take a look in the chat.

[Rim Cothren] 16:29:58

As usual, has been very good about dropping lots of links in chat, a lot of good materials that Ray may have referenced during the discussion.

[Rim Cothren] 16:30:09

Steven, one real quick question for you from me, the work that you were talking about here today. That was sponsored by another organization. Do you want to mention that here at all?

[Steven Lane] 16:30:24

Well, a number of organizations have been involved in this work. This, this came out of a number of discussions that occurred after the dogs decision some of which occurred at Civitas. We've been doing work within sequoia. There. There have been many organizations involved, so I think the the folks at planned parenthood, you know, as the authors of Ab. 3 52, you know, have been very.

[Steven Lane] 16:30:49

Supportive of this effort as well. So I'm not sure, Rim, if you were thinking of one in particular. But lots of folks have been trying to drive this forward.

[Rim Cothren] 16:30:58

Thanks, Stephen.

[Rim Cothren] 16:31:00

Are there.

[Rim Cothren] 16:31:02

Questions for any of the presenters here.

[Rim Cothren] 16:31:05

From the task.

[John Helvey] 16:31:11

I didn't see it covered. I may have missed it, but.

[John Helvey] 16:31:15

In maternal field medicine there are selective reduction.

[John Helvey] 16:31:20

Codes that I'm sure were they listed in that code set.

[John Helvey] 16:31:24

Categories or.

[Raymonde Uy] 16:31:28

Yes, thanks, John, for asking. Yes, those are included for those who don't know what John is saying.

[Raymonde Uy] 16:31:34

Selective reduction is, for example, you have a multiple gestation or twin.

[Raymonde Uy] 16:31:38

Club.

[Raymonde Uy] 16:31:38

You know, Quincy Triplet, those things, but there is one fetus that may not be, or is deemed by the obstetration to be, not viable.

[Raymonde Uy] 16:31:48

And those can be selectively.

[Raymonde Uy] 16:31:51

How do you say this removed from the pregnancy so that it doesn't.

[Raymonde Uy] 16:31:56

Doesn't complicate the other fetuses in registration.

[Raymonde Uy] 16:32:00

Right, those are included.

[Raymonde Uy] 16:32:04

Thank you. Great question.

[Rim Cothren] 16:32:09

Pray. There's also a question that was in the Q. And A. Are you planning on doing mapping to related concepts, such as family planning.

[Raymonde Uy] 16:32:17

Thank you very much for asking that question. We do, in fact, have.

[Raymonde Uy] 16:32:22

Done this mapping. Unfortunately, it does not specifically relate to A, B 3.

[Raymonde Uy] 16:32:27

But I will say that we are. I'm currently building more value set specifically to.

[Raymonde Uy] 16:32:33

Record or

[Raymonde Uy] 16:32:36

To represent molar or a topic.

[Raymonde Uy] 16:32:39

Fertility art fertility lab testing. For example.

[Raymonde Uy] 16:32:44

Ivf or assisted reproductive technologies and others. In the wording. It also includes mammography or pregnancy, related nutrition services, and you're handling of postpartum care products, and we can those are almost done. But we ha! We have some.

[Raymonde Uy] 16:33:02

Block a blockages from my side, but they are in progress. Thanks for asking.

[Steven Lane] 16:33:07

And Ray. There was another question by Lucy Johns about performance or reversal of genital mutilation.

[Steven Lane] 16:33:14

I don't know that.

[Raymonde Uy] 16:33:16

Hmm.

[Steven Lane] 16:33:17

We've looked at that specifically.

[Raymonde Uy] 16:33:18

That's a very good question, Lucy, for asking that question. It does, in fact, very serious. I think the issue with that would be.

[Raymonde Uy] 16:33:26

What kind of specific codes are going to be used? Is it this realm of Obgn, or in the realm of plastic surgery?

[Raymonde Uy] 16:33:34

And I'm sure there are procedure codes.

[Raymonde Uy] 16:33:36

That relate to the actual repair. For example, depending on what type of mutilation or what type of injury has been.

[Raymonde Uy] 16:33:44

Been afflicted on these patients. Then we can definitely build this out this out. If you have a clinical use case and you have a community.

[Raymonde Uy] 16:33:52

Of of patients that do need this type of of build out of these value sets. Please reach out to me, and there are other folks in this.

[Raymonde Uy] 16:34:00

This task force thanks so much.

[Rim Cothren] 16:34:03

Thanks. I'm going to go ahead and move us on, Hans. You had put a few materials together from Ehr. Do you want to.

[Rim Cothren] 16:34:12

Present, that material, real, quick. Please.

[Hans Buitendijk] 16:34:14

Sure. And for those new on the phone. My name is Hansnick. I'm here representing the Ray? That's an organization of about 2930 ehr. Vendors.

[Hans Buitendijk] 16:34:27

Of all sizes, and covering a wide variety of settings.

[Hans Buitendijk] 16:34:30

We have started in that organization, and and otherwise I'm with oracle health.

[Hans Buitendijk] 16:34:37

But I'm here. On behalf of year 8 we have started with an array to a new task force that is going to be focusing on.

[Hans Buitendijk] 16:34:47

Pricing and consent challenges and issues, and clearly having access to a sensitive data like

[Hans Buitendijk] 16:34:56

Reproductive health, as described in A. B 352 in other jurisdictions. It's A, it's an important topic to to talk about and figure out how we can manage that. And if you can go to the next slide, one of the the things that we are looking at is that in the end or we are the source of the starting point of much of this information.

[Hans Buitendijk] 16:35:18

However, they're being distributed and and shared through networks or secondary data use and analytics, whatever the source starts with the with the providers, typically.

[Hans Buitendijk] 16:35:31

So when we are looking at that and trying to figure out, what do we need to address so that we can, as data is more and more automatically shared.

[Hans Buitendijk] 16:35:42

And in support of different workflows different queries. How can we do that with the least amount, if not.

[Hans Buitendijk] 16:35:48

0 human participation in that at a high level of comfort and reliability that we include and exclude data. Otherwise individual users will offer every query for every transaction. Can I send this or not? So so the key challenge that we have is that, how can we do this in a computable automated fashion. So some of the concepts that we had then looking at is that if we are the data holder in the middle.

[Hans Buitendijk] 16:36:13

We are the Hr. And we are interacting with a target, either because we need to send something or they're asking for the information.

[Hans Buitendijk] 16:36:21

We somehow need to. Understand. Can we do that?

[Hans Buitendijk] 16:36:25

Do we have the authority based on who's asking, who's the target and where we are jurisdictional across jurisdictional within a jurisdiction depending on other factors is that can we do that?

[Hans Buitendijk] 16:36:37

So before we go into release a Phi in there, and there are a number of different things that are in play there, that all need to be looked at together. It's not just one piece. We need to look at all the pieces together, to to have a a holistic, comprehensive.

[Hans Buitendijk] 16:36:54

And we need to keep in mind is that.

[Hans Buitendijk] 16:36:57

And that's the current state where we're in that when we talk about some of the standards they're either Cda based or they're based, or their version 2 based. They're all capable of some form of tagging that the standard supports that.

[Hans Buitendijk] 16:37:11

Your question is, what should that be? And the other question is that which events.

[Hans Buitendijk] 16:37:18

Another question is, is that what's the definition of that per jurisdiction?

[Hans Buitendijk] 16:37:23

So when we look at that, we have 3 types of rules that we need to consider, we have to privacy rules by jurisdictions, and they can vary.

[Hans Buitendijk] 16:37:32

They may have different definitions, different value sets that they may want to use. Raymond did a great job, and the rest of the team to define a likely set of values for a reproductive care.

[Hans Buitendijk] 16:37:48

And others, but that may vary from State to State. So California has one, Maryland has another one, etc. So we really need to understand those privacy rules that we can then assess and evaluate as we exchange. Similarly, patient may provide consent to share or not to share some of the data, so they may to some extent overrule that they may need to. the agreement of of a provider for.

[Hans Buitendijk] 16:38:13

That. But in the end there are going to be rules that patient defines as to what can or cannot be shared. On top of, or next to the privacy rules so underlying. That is where these aspects of notifiable events. when I'm sharing with somebody else results and admission, and er visit, etc. Is that already starting to become sensitive.

[Hans Buitendijk] 16:38:38

I need to have an understanding of the sense of data and categories and other things that we are still learning. So if you go to the next slide. We put together a couple of different of the challenges that as we go through it, that need to be addressed to be able to successfully roll this out.

[Hans Buitendijk] 16:38:54

There was a lot of work going on. There are abilities to connect flags and information metadata to transactions.

[Hans Buitendijk] 16:39:02

We need to make sure that we think about it, not just as.

[Hans Buitendijk] 16:39:06

Cda.

[Hans Buitendijk] 16:39:07

Or fire or version 2, but proprietary, otherwise, there are many different ways in which data is exchanged, that th. This challenge is something that from an organizational perspective or provider perspective data is shared or not. I don't care what you use as the method to do it. It is being shared. And can you do that? So that's that's critical that we always look at it across.

[Hans Buitendijk] 16:39:30

Any of the methods. And what can we do to to make that work? And that will not be an overnight progression. But I just need to point it out that the scope is larger than just things working with fire. Apis, that's not enough.

[Hans Buitendijk] 16:39:45

Nor Cdas.

[Hans Buitendijk] 16:39:46

No version. 2, so when we break it out is that in privacy rules, what are some of the challenges and needs patient rules and infrastructure. To make this work, I think that might help inform some of our discussion further to help make sure. Are we addressing all the pieces of the puzzle.

[Hans Buitendijk] 16:40:03

In a reasonable fashion. Some of them are more immediate, otherwise we can work on other ones. We know that that it's a big puzzle. But what is on the key? Things that we are looking at that need to be addressed and and get clarity on.

[Hans Buitendijk] 16:40:16

So starting with the privacy rules is where we're looking at any of the rules need to be computable.

[Hans Buitendijk] 16:40:22

They therefore cannot be ambiguous.

[Hans Buitendijk] 16:40:26

We have to be consistent in part of that. The information is shared and reshared and reshared, so the the rules need to be applied consistently as they move around.

[Hans Buitendijk] 16:40:38

within a jurisdiction across New York sessions doesn't matter. It's it's the same thing.

[Hans Buitendijk] 16:40:43

And typically, we find is that rules are not well defined, that privacy level, there is space for interpretation, and that then we can have this disconnect between the different data sources.

[Hans Buitendijk] 16:40:54

That some share, some don't, and that's not consistent. So that's a challenge.

[Hans Buitendijk] 16:40:59

There's a lot of good work that we talked about earlier, that that we heard about sensitive data definition, what data may be considered sensitive.

[Hans Buitendijk] 16:41:08

And we need to have more definition of sensitively flags.

[Hans Buitendijk] 16:41:13

Because some of it I can derive, as was described by Mohammed or Raymond. Clearly I can do that based on the data itself. There is a drug, a diagnoses that will be indicative of that.

[Hans Buitendijk] 16:41:25

But other times it depends on context.

[Hans Buitendijk] 16:41:27

It depends on the data itself. That is not quite useful. So I have to tag it to market, because in this instance it's sensitive. In another instance. It's not.

[Hans Buitendijk] 16:41:38

It's part of documents.

[Hans Buitendijk] 16:41:40

It's part of data sets. So I need to be able to to have effectively a summary view, so that when that data set or document is is to be exchanged.

[Hans Buitendijk] 16:41:51

I know that it contains something, and therefore what do I do? Stop it, redact it, whatever the choices are.

[Hans Buitendijk] 16:41:58

Touch with. I need to understand data in there.

[Hans Buitendijk] 16:42:00

And I cannot do that all the way to always runtime. I I need to have abilities to hold on to that and persist that. So our need there is that they're defined. Work is in progress.

[Hans Buitendijk] 16:42:12

Those agreement.

[Hans Buitendijk] 16:42:13

That is also in progress and promulgated effectively have they been adopted, so that for this rule.

[Hans Buitendijk] 16:42:20

That's the data set that we agree and represents.

[Hans Buitendijk] 16:42:22

Unambiguously. If that changes over time. That's okay. But then we need to have process as well that those January one, whatever year that's the new value set that we that we operate with. So so there we have to grow into that. And that's clearly an immediate need to get that establish as soon as possible. So take the work that's done, and apply it and make sure that it is recommended.

[Hans Buitendijk] 16:42:48

That it's agreed to so that everybody can use it. Certified software or not.

[Hans Buitendijk] 16:42:53

The old data can use the same set and then start the process of of recognizing it.

[Hans Buitendijk] 16:43:02

And we sensitivity having an agreed to set as well, so that appropriate support can be applied, that individuals can then tag data, perhaps with some rules around it that can be implemented electronically, but that that can start as well.

[Hans Buitendijk] 16:43:18

From a patient perspective. Same issue of computable rules. Most of the rules now are in some Pdf handwritten or other form.

[Hans Buitendijk] 16:43:27

That really needs to be established also in the computable fashion. So once they are agreed to, we, we can use those and the and the cert in a computable fashion that yes, this data, whatever the privacy rule says, I can share, I cannot share.

[Hans Buitendijk] 16:43:43

So I need to have that combination. And it's essence the same data set.

[Hans Buitendijk] 16:43:48

With with some variations, that there.

[Hans Buitendijk] 16:43:51

Privacy, rules might define one set.

[Hans Buitendijk] 16:43:54

As a patient I might consider all the data sensitive as well.

[Hans Buitendijk] 16:43:58

So the the scope is potentially larger. Not to say that we have to immediately go there.

[Hans Buitendijk] 16:44:05

Had some great conversations with Mohammed and others as well. Hey, there needs to be some progression there. We we we can start with with areas that we might have some templates and otherwise, but at the same point in time.

[Hans Buitendijk] 16:44:17

We need to get to the same point.

[Hans Buitendijk] 16:44:20

So that there are documentation tools.

[Hans Buitendijk] 16:44:22

Common rules, data sets.

[Hans Buitendijk] 16:44:24

Work going on in 8 to 7 that Mohammed and others are leading and driving to make progress. There.

[Hans Buitendijk] 16:44:31

But that needs to be in place as well to to have the full set.

[Hans Buitendijk] 16:44:35

And then, lastly, from an infrastructure perspective. Where do we maintain these rules so that I can know where to get the latest version of it. And the latest definition of that is it at a jurisdictional level? Well, probably good for privacy rules. They define them.

[Hans Buitendijk] 16:44:52

Might be a good place to to store the computable expression of that, or have it available, or in some common library.

[Hans Buitendijk] 16:44:59

When it comes to patient rules it gets a little bit more challenging. Is it provider focused? Is it the patient? Is it the jurisdiction like a state. I think there's a still a lot of work to be done there. But in essence we also need to know where are all the rules of the patient, so that as a data holder.

[Hans Buitendijk] 16:45:17

I can evaluate that, that the data can be shared.

[Hans Buitendijk] 16:45:22

What kind of assumptions can we make as we now implement? We have got the rules across different areas.

[Hans Buitendijk] 16:45:29

Across the organization, jurisdictional organizations.

[Hans Buitendijk] 16:45:32

Can I assume that they internally recognize that? Or do I have to know as the data that the requester is in a large organization that spans multiple jurisdictions.

[Hans Buitendijk] 16:45:43

Who exactly is asking.

[Hans Buitendijk] 16:45:44

Or is it the organization that then in turn can resolve.

[Hans Buitendijk] 16:45:48

Any kind of cross jurisdictional challenges or adjudication of the rules.

[Hans Buitendijk] 16:45:55

So where are the locations? Who are who are they? How can we work with that? What's the role of networks in helping disambiguate that so many questions in that area that need to be addressed to make it scalable and practical. And again, last, is any exchange or method is what we need to look at.

[Hans Buitendijk] 16:46:15

Not just a Cda, not just fire, not just v, 2.

[Hans Buitendijk] 16:46:20

So what that means is that the needs that we have where these rules repositories, so that where they are defined in a computable fashion. What is the jurisdiction of the target recipient.

[Hans Buitendijk] 16:46:33

How do we know that? And then many times we do.

[Hans Buitendijk] 16:46:36

Based on the request. Sometimes.

[Hans Buitendijk] 16:46:38

It is part of a large organization. We might not.

[Hans Buitendijk] 16:46:42

And the the exchange method.

[Hans Buitendijk] 16:46:45

So.

[Hans Buitendijk] 16:46:47

Any data holder from a from a 3, 52 perspective or otherwise, any data holder, not just the Hrs.

[Hans Buitendijk] 16:46:57

we'll have this kind of need, because, as we share and we share.

[Hans Buitendijk] 16:47:02

Is that the rules do not really change.

[Hans Buitendijk] 16:47:04

It's not just the Hrs that we need to look at, not just certified software. And we need to look at. So this is in the in a nutshell, the the big one. So I'm sure they're more. And as we learn more, the other questions will come up. But that's what we collectively need to work on for the data holders, systems.

[Hans Buitendijk] 16:47:23

To be able to manage the intent of A. B 3, 52, and taking the work that has happened so far, and get it to a point where it is implementable, scalable, and otherwise. So if you can go to the last slide throughout that old.

[Hans Buitendijk] 16:47:39

Is, is where we are constantly from an Ehr perspective, needing to understand and balance these 2 sides of the coin. On the one hand, we need to get as much as possible complete data for improved clinical decision support.

[Hans Buitendijk] 16:47:54

At same point in time. We need to consider the potential harm to patients if data is being shared that should not have been shared.

[Hans Buitendijk] 16:48:01

So that's an ongoing evaluation as well. That will constantly drive the content of the rules of the data sets, etc. So it's going to be a dynamic area. But the principles of the infrastructure we need to have.

[Hans Buitendijk] 16:48:18

are consistent across that space that we are looking at, and.

[Hans Buitendijk] 16:48:22

That format from a data perspective. H, it perspective there, that we need to have clarity around an agreement to take these kinds of rules.

[Hans Buitendijk] 16:48:34

Very specifically and translate them into something that is implementable, scalable, computable. To to a support. The requirements.

[Hans Buitendijk] 16:48:44

I'll stop there.

[Rim Cothren] 16:48:45

Thanks, Hans. I'm just watching the clock here and noting that we're about time for public comment. I'm going to bleed into the public comment period a few minutes, so that people have chance to ask at least a few questions.

[Rim Cothren] 16:48:58

Here, but we'll try to keep it short, Steven. I see your hand up.

[Steven Lane] 16:49:03

Yeah, I just wanted to really thank Hans for that presentation for the work that he's helping to lead within the hra. I mean, as you say, the Ehr is kind of where this data starts and so having the Hr vendors involved in this discussion is critical to our ability to actually move anything forward. Right? You have to be able to, you know. Get these tags into the system, maintain them to send them.

[Steven Lane] 16:49:27

With the data, etc. So this is really.

[Steven Lane] 16:49:31

Wonderful. It's the 1st time, Hans, I've heard you give this talk. And and it's very exciting, because it actually describes a a path forward for collaboration that can actually put some of these things into practice.

[Rim Cothren] 16:49:45

Thanks, Steven Joy. I see your hand up.

[Joe Sullivan] 16:49:47

Oh, thank you, and for those of you don't know. I'm Joe Sullivan.

[Joe Sullivan] 16:49:53

But I've also been a firefighter still active.

[Joe Sullivan] 16:49:57

So I appreciate what you shared here, Hans. Because that it's not just about the fire. HI. 7. Because again, being from the field and the systems that I'm managing. Sometimes I just need to know a yes, no.

[Joe Sullivan] 16:50:14

I don't need to have specific information shared with me. It's just will this person.

[Joe Sullivan] 16:50:21

You know the

[Joe Sullivan] 16:50:23

Do they have.

[Joe Sullivan] 16:50:25

Are they seeing a position or for prenatal support? Right? Things like that? It can. It just speeds up the field assessment, and, you know, helps the medic and in the field. So.

[Joe Sullivan] 16:50:39

Anyways.

[Joe Sullivan] 16:50:40

How the fact you're talking about sharing information.

[Joe Sullivan] 16:50:45

I think it's great.

[Joe Sullivan] 16:50:48

And then.

[Joe Sullivan] 16:50:49

Jumping back to the 1st presentation.

[Joe Sullivan] 16:50:53

They? There was.

[Joe Sullivan] 16:50:54

A lot of.

[Joe Sullivan] 16:50:55

The physician codes and things like that were there codes in there for any updates for mental cognitive health.

[Raymonde Uy, MD, MBA, ACHIP] 16:51:04

Yes, we. I have that separately on a different project, although it's not within the bounds of Ab. 3.

[Raymonde Uy, MD, MBA, ACHIP] 16:51:11

But reach out to me if you guys need it. Happy to support.

[Joe Sullivan] 16:51:15

I'll need it. Thank you.

[Raymonde Uy, MD, MBA, ACHIP] 16:51:15

Oh, I have built of those. Yeah.

[Rim Cothren] 16:51:20

John, I see your hand up.

[John Helvey] 16:51:23

Just want to thank Hans for the great presentation you just highlighted the complexities that.

[John Helvey] 16:51:29

We all face, whether your Emr, whether an HIE.

[John Helvey] 16:51:33

Trying to exchange in under these new rules that are jurisdictional.

[John Helvey] 16:51:39

So thank you for that.

[John Helvey] 16:51:41

Has.

[John Helvey] 16:51:43

There been any? Look at.

[John Helvey] 16:51:46

Non code set of data, for example, history and physicals. Progress notes.

[John Helvey] 16:51:53

Provider Documentation.

[John Helvey] 16:51:54

There's a lot of things that.

[John Helvey] 16:51:57

Don't necessarily come out in a code set, or have been coded in some way, shape or form.

[John Helvey] 16:52:03

That are included in a H. And P, or progress.

[John Helvey] 16:52:08

That the only way that I can think of handling that would be some level of natural language processing that redacts that information.

[John Helvey] 16:52:16

Or of some something of that nature.

[John Helvey] 16:52:20

So I turn it back over to you.

[John Helvey] 16:52:22

Thanks.

[Steven Lane] 16:52:23

Yeah, I'll just. I'll just make a comment. There, John, I mean, this, this question gets raised every single time we have this discussion. You know that so much of this.

[Steven Lane] 16:52:32

Sensitive information is hidden in the text of notes, or in, you know, images or or other kinds of recordings.

[Steven Lane] 16:52:39

And this it's simply true.

[Steven Lane] 16:52:41

You know, and nobody is tackling that yet. I mean, this is this is a crawl walk, run.

[Steven Lane] 16:52:46

Sort of thing. And and the crawl is definitely looking at codified data, identifying that which needs to be managed differentially and then putting that into place. But then we got a lot to do before we can get to Nlp and AI. And you know, in, you know, inferring this sort of thing you're absolutely right.

[Hans Buitendijk] 16:53:05

Yeah. And and to add to that is from our discussion in the, it's 1 of the challenging areas.

[Hans Buitendijk] 16:53:13

Very challenging. There are samples where in individual organizations have started to make progress in that space on how can I evaluate Nlp, otherwise that the content is sensitive. And then the question becomes, what is the sensitivity flag that I attach that? So it's it's that document slash notes. Whatever that has data in it, that Co that that needs.

[Hans Buitendijk] 16:53:39

To collectively be marked as sensitive. How do we do that? Is it that the flag is enough to say it is sensitive for for reproductive health. Do you have to start to qualify more of the details behind it? How do we do that? And and what are then the recognized approaches to that. So that in the end the metadata around that that notes that document, that data set.

[Hans Buitendijk] 16:54:04

Is universally, consistently interpreted as you share it around, so it doesn't make me mean that we cannot make progress, but it will be one of the tougher areas. it may require times, also that a user needs to as they create that that note already needs to proactively tag the data? What's the best flow? How do we work that out? What's the balance between that? And having automated tools.

[Hans Buitendijk] 16:54:30

To suggest that it might be sensitive and then let the the user. So I think those are just kind of the more challenging parts in this entire puzzle that we need to put together. So clearly recognized no universal answer. Yet.

[Rim Cothren] 16:54:46

Thanks, Hans. We really need to turn to public comment, Ray. I'm gonna ask you to either hold your thought or drop it in chat if it if that works for you.

[Rim Cothren] 16:54:54

Hans, I'll point out to you that there's also one question in.

[Rim Cothren] 16:54:58

Qa. On the role of Ehra, that you might respond to.

[Hans Buitendijk] 16:54:59

Okay.

[Rim Cothren] 16:55:02

Alice, if we can open up for public comment, please.

[Alice K - Events] 16:55:07

Absolutely. Thank you, M.

[Alice K - Events] 16:55:09

Members of the public must raise their hand and zoom. Facilitators will unmute each member of the public for them to share comments.

[Alice K - Events] 16:55:17

The chair will call on individuals in the order in which their hands were raised. Individuals will be recognized for up to 2 min, and are asked to state their name and organizational affiliation at the start of their remarks.

[Alice K - Events] 16:55:29

If you logged in via zoom interface, you can press, raise hand at the bottom of your screen, selected to share your comment. You'll receive a request to unmute.

[Alice K - Events] 16:55:37

Please ensure you accept before speaking. And if you called in via phone, only press Star 9 on your phone to raise your hand.

[Alice K - Events] 16:55:44

Listen for your phone number to be called by the Moderator, and if selected to share your comment.

[Alice K - Events] 16:55:49

Please ensure you're unmuted on your phone by pressing Star 6.

[Alice K - Events] 16:55:54

With that. We don't have any hands raised at this time.

[Hans Buitendijk] 16:56:00

Do you want me to.

[Rim Cothren] 16:56:00

So give people a minute.

[Hans Buitendijk] 16:56:02

You want me to address the question, live.

[Rim Cothren] 16:56:05

It's up to you, Hans. We'll give people just a couple of minutes for public comment, and if

[Rim Cothren] 16:56:10

If we don't get any public comment, there's time. Yes, you can do it. Live if you prefer.

[Hans Buitendijk] 16:56:15

That's fine!

[Hans Buitendijk] 16:56:17

I'm talking fast.

[Alice K - Events] 16:56:27

Still no hands at this time.

[Rim Cothren] 16:56:33

Give it another 30 seconds.

[Rim Cothren] 16:56:48

Well, Alice, if we don't have any public comment, I am going to hand the mic back over to Hans. If you'd like to to address Lucy's question.

[Rim Cothren] 16:56:58

The other folks on the call haven't seen her questions. You might summarize her question real quickly.

[Rim Cothren] 16:57:03

And then, Ray, if there's time we'll turn back to you.

[Hans Buitendijk] 16:57:07

Sure the Lucy's asking a question about whether the place where Hr. Vendors designed vendor designers look for guidance about what needs to be included, revised, and existing Ehrs, or another way to put it.

[Hans Buitendijk] 16:57:21

What are the incentives for Ehr vendors to pick all this up? I think there's 2 parts to to that 2, 3 parts one is that the as an organization is focusing predominantly at the policy aspects, the overall directions and trends and collaborations between their clients, providers and Hrt. Vendors to move things forward. So you do not see much in the.

[Hans Buitendijk] 16:57:46

In the work of detailed guidance. We have done some work on usability, best practices, or patient safety best practices that that can work across different organizations, vendors. So that where we say, yeah, we should really should align best practices there. But when we go to the level depth that is needed here. It typically then goes to an 8 0. 7, where.

[Hans Buitendijk] 16:58:11

A group is working on patient consent, or another group is working in on the flags or not. A group is working. That's where Ehr designers and others are collaborating to really figure out what are the common standards that we need to make something like this work.

[Hans Buitendijk] 16:58:29

So that's on the one side, on on what the role of, is. But for these kind of discussions like today or a related topic. So that's where we typically look at the for the the the technical details is where we go to 8 0. 7, and other places.

[Hans Buitendijk] 16:58:48

Same members different people at times. To the question. The second part what incense in ehr vendors to pick this all up.

[Hans Buitendijk] 16:58:57

That is a typically, and it's not unique to this. It's a combination. What's the demand or the regulations? Is there? A patient safety issue etc, etc. So there's number of different things that will drive how to do it with things like this. Topics like this. It gets challenging because we all need to do.

[Hans Buitendijk] 16:59:20

A lot of things the same way.

[Hans Buitendijk] 16:59:22

If I do something with my oracle head, or Danielle friend was on earlier, you might have seen us from epic, that with her head on, we might do it individually.

[Hans Buitendijk] 16:59:32

But we might not be able to talk.

[Hans Buitendijk] 16:59:35

And particularly with this, it's all about doing it the same way to make that happen. So now at that point it becomes a is everybody ready? What's going to push that? So you see, certification, a topic like this would typically be driven by that.

[Rim Cothren] 16:59:51

Thanks. Hans.

[Rim Cothren] 16:59:52

I'm I'm gonna close out our meeting for today. Then just I'd ask everybody to reflect on today's discussion. Bring any other questions. You have to our next meeting. We'll be meeting again in 2 weeks. During the same time. Slot.

[Rim Cothren] 17:00:06

Also, if anyone, any of the members of the task have a specific topic that you want to make sure that we touch on in our last meeting.

[Rim Cothren] 17:00:14

Feel free to drop me an email or drop an email into the dxf.

[Rim Cothren] 17:00:20

At chs.ca.gov.

[Rim Cothren] 17:00:24

Email, address.

[Rim Cothren] 17:00:26

Thanks everyone for attending today. I appreciate it, and we'll see you all again in a