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NOTICE OF PUBLIC MEETING

Data Exchange Framework (DxF) Stakeholder Advisory Committee Meeting #2

June 18, 2026
Meeting Minutes

DxF Stakeholder Advisory Committee Voting Members Attending In-Person: Dr. Jennifer Sayles, PopHealth Learning Center (Chair); Joan Allen, SEIU UHW; William Barcellona, America's Physician Groups; Colleen Chawla, San Mateo County Health; David Ford, CMA Physician Services Organization; Aaron Goodale, MedPOINT Management; Dr. Scott MacDonald, UC Davis Health; Ali Modaressi, LANES; Eric Nielson, County Welfare Directors Association of California (CWDA); Lucy Saenz,6 California Primary Care Association; Mark Savage, Savage & Savage LLC; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Julie Silas, Homebase.

DxF Stakeholder Advisory Committee Ex Officio Members Attending In-Person: Amanda Levy, California Department of Managed Health Care (DMHC); Taylor Priestley, Covered California; Dr. Linette T. Scott, California Department of Health Care Services (DHCS); Jared Shinabery, California Public Employees' Retirement System (CalPERS).

Attending Virtually: Yvonne Choong, California Association of Health Facilities; Rebecca Fisher, California Department of Public Health (CDPH); Andrew Kiefer, Blue Shield of California; Huihui Xu on behalf of Ann M. Nakamura, California Department of Developmental Services (DDS); Shannon Rohall, California Department of Social Services (DSS); Lee Tien, Electronic Frontier Foundation.

Members Not in Attendance: Katie Heidorn, California Health Care Foundation; Elizabeth Basnett, California Emergency Medical Services Authority (EMSA); Janna Lowder-Blanco, California Department of State Hospitals.

Presenters: Elizabeth Landsberg, Director, HCAI; Michael Valle, Assistant Director, HCAI; Jacob Parkinson, DxF Program Director, HCAI; Robert M. Cothren, PhD, Data Exchange Framework Consultant; Dr. Jennifer Sayles, CEO, PopHealth Learning Center (Chair); Athena Chapman, President, Chapman Consulting.

Public Attendance: A total of 62 public attendees

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Agenda Item I: Welcome and Introductions
Jennifer Sayles, MD, MPH, Committee Chair

Dr. Jennifer Sayles, Committee Chair, opened the meeting, welcomed advisory committee members and members of the public, and conducted roll call of voting and ex officio members. A quorum was established.

Dr. Sayles then asked for a motion to approve the minutes from the April 16, 2026, DxF Stakeholder Advisory Committee meeting. Mark Savage, Savage & Savage LLC, motioned to approve the minutes, and Dr. Scott MacDonald, UC Davis Health, seconded the motion. Dr. Sayles invited committee discussion and public comment on the minutes; there were no comments from the committee or the public.

The following members voted to approve the April 16, 2026 meeting minutes: Dr. Jennifer Sayles (Chair), Joan Allen, William Barcellona, Colleen Chawla, Yvonne Choong, David Ford, Aaron Goodale, Dr. Scott MacDonald, Ali Modaressi, Eric Nielson, Lucy Saenz, Mark Savage, Kiran Savage-Sangwan, Julie Silas, and Lee Tien.

Katie Heidorn and Andrew Kiefer were absent from voting.

The motion to approve the April 16, 2026, meeting minutes was carried by a vote of 15 in favor.

Questions and comments from the committee:

There were no questions or comments from the advisory committee.

Public comment:

There was no public comment.

Agenda Item II: Department Updates

Elizabeth Landsberg, Director

Director Landsberg provided department updates relevant to the advisory committee's work. She discussed the Distressed Hospital Loan/Grant Program, including the prior $300 million distressed hospital loan program, the $25 million distressed hospital small grant program signed on May 7, 2026, and awards to four hospitals. She also noted ongoing budget and policy discussions related to financially distressed hospitals.

Director Landsberg also provided an update on the Rural Health Transformation Program, describing the national $50 billion program, California's year-one award, and

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the state's approach to complement existing programs while targeting gaps in rural health delivery systems, workforce, and infrastructure. She described three California initiatives approved by the Centers for Medicare & Medicaid Services (CMS): the Transformative Care Model, rural workforce development support, and technology and tools. She noted that the technology and tools component includes investments in electronic health records, data exchange and interoperability, telehealth expansion, and cybersecurity.

Director Landsberg noted tight timelines for obligating funds, forthcoming Requests for Applications, engagement with Tribal communities, a Tribal set-aside floor, and plans to establish a Rural Health Policy Council. She also noted potential alignment between the Rural Health Policy Council and the DxF Stakeholder Advisory Committee.

Questions and comments from the committee:

There were no questions and comments from the advisory committee.

Public comment:

There was no public comment.

Agenda Item III: DxF Program Updates and Purchaser Contracting Requirement Overview

Michael Valle, Assistant Director

Jacob Parkinson, DxF Program Director

Michael Valle, Assistant Director, reminded the advisory committee that Senate Bill (SB) 660 requires the committee to make recommendations and provide input for HCAI's July 2027 legislative report. He noted that the committee's input may also inform HCAI of administrative changes and potential statutory changes for legislative consideration. Mr. Valle reviewed updates to the committee discussion topics, including additional time for discussion of demographic and health-related social needs data and the addition of the Fast Healthcare Interoperability Resources (FHIR) roadmap and technical standards topic based on committee prioritization. He also previewed the Qualified Health Information Organization (QHIO) Program discussion and the additional public comment opportunity planned for that agenda item.

Jacob Parkinson, DxF Program Director, provided DxF program updates, including revised Frequently Asked Questions, a Participant Verification Standard Operating

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Procedure, conclusion of the Data Sharing Agreement (DSA) Signatory Grant Program, anticipated amendments to the Participant Directory Policy and Procedure, upcoming outreach to required signatories that have not yet signed the DSA, forthcoming intake forms for misclassification or extenuating circumstances, and one QHIO's voluntary withdrawal from the program.

Mr. Parkinson then provided an overview of current purchaser contracting requirements. He noted that SB 660 requires specified participants to execute the DSA as a condition of contracting with DHCS, CalPERS, or Covered California beginning July 1, 2026. He explained that purchaser contracts meet the SB 660 requirement, while additional contracting elements vary by purchaser. Examples included Covered California's QHIO participation requirement, DHCS and Covered California requirements related to admission, discharge, and transfer (ADT) event notifications, and DHCS requirements for subcontractors to execute the DSA. He noted that the advisory committee will have a more substantive discussion in the future regarding purchaser contracting requirements, potential updates, and opportunities for alignment.

Questions and comments from the committee:

Advisory committee members discussed the Participant Verification Standard Operating Procedure and suggested that HCAI consider a more public-facing name because the process also provides a way to report concerns. Members asked about transparency in determining whether an entity qualifies as a health or social services organization and whether HCAI would consult subject matter experts. Mr. Parkinson noted that HCAI could circulate the procedure and described the process as an effort to introduce review of organizational legitimacy. Members also asked which QHIO is voluntarily withdrawing; Mr. Parkinson identified Serving Communities Health Information Service and noted that the request remained under review. Advisory committee members also discussed the emerging issue of artificial intelligence (AI) agents accessing health care data through exchange mechanisms, including potential beneficial uses, risks of misuse, privacy violations, data leakage, protections for homelessness and social services data, and the need for guardrails.

Public comment:

The public encouraged California to develop careful policies and procedures for vetting new types of exchange participants and exchange purposes, drawing from experience with Trusted Exchange Framework and Common Agreement (TEFCA). The public also commented that the Participant Verification Standard Operating Procedure may not fully

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achieve its intended purpose because national networks and frameworks have their own data use and reciprocity requirements and encouraged HCAI and the committee to consider revisiting how the procedure is designed.

Agenda Item IV: FHIR Roadmap: Technical Standards Advancement

Jacob Parkinson, DxF Program Director

Robert M. Cothren, PhD, DxF Consultant

Mr. Parkinson introduced the agenda item, noting that the discussion responded to the committee's prioritization of a FHIR roadmap as a discretionary strategic initiative. He identified the goals of reviewing the DxF technical standards advancement process, reviewing federal initiatives advancing FHIR, discussing priorities for FHIR Adoption and other technical standards, and recommending an approach to drafting a DxF roadmap for FHIR Adoption.

Robert M. Cothren, PhD, described the technical standards advancement process. He explained that the process is designed to consider new and maturing standards for potential inclusion in the DxF while generally relying on national and federally recognized standards rather than creating new California-specific standards. Dr. Cothren reviewed how technical standards are reflected in DxF policies and procedures, including the Data Elements to Be Exchanged Policy and Procedure and the Technical Requirements for Exchange Policy and Procedure. He described the annual process for stakeholder input, potential convening of a Standards Workgroup by HCAI, public comment, amendments to policies and procedures, and implementation timelines.

Dr. Cothren provided background on FHIR, noting that it is intended to modernize health care data exchange using more granular data elements and modern application programming interface (API) approaches. He reviewed federal and national initiatives, including Office of the National Coordinator for Health Information Technology Health IT Certification requirements, CMS interoperability and prior authorization rules, the FHIR roadmap for TEFCA exchange, and the Gravity Project's tiered approach to social determinants of health data exchange.

Mr. Parkinson summarized the case for a DxF roadmap for FHIR adoption, noting growing federal momentum, limited FHIR use in California, continued reliance on legacy exchange methods, limited QHIO adoption due to low demand and lack of DxF requirements, gaps in federal requirements for providers, and limitations of the TEFCA roadmap for certain DxF exchange types, required purposes, and participants. He

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asked the advisory committee to discuss priorities for a DxF FHIR roadmap and whether HCAI should convene a Standards Workgroup in 2026 to develop a draft roadmap for advisory committee review in early 2027.

Dr. Sayles then asked for a motion on the following question: Should HCAI convene the Standards Workgroup in 2026 to develop a draft DxF roadmap for FHIR adoption for the advisory committee to review in early 2027?

Dr. Scott MacDonald, UC Davis Health, motioned to consider the question, and Mark Savage, Savage & Savage LLC, seconded the motion. Dr. Sayles then invited committee discussion and public comment on the topic.

The following members voted for HCAI to convene the Standards Workgroup in 2026 to develop a draft DxF roadmap for FHIR adoption for the advisory committee to review in early 2027: Dr. Jennifer Sayles (Chair), Joan Allen, William Barcellona, Colleen Chawla, Yvonne Choong, David Ford, Aaron Goodale, Andrew Kiefer, Dr. Scott MacDonald, Ali Modaressi, Eric Nielson, Lucy Saenz, Mark Savage, Kiran Savage-Sangwan, Julie Silas, and Lee Tien.

Katie Heidorn was absent from voting.

The motion for HCAI to convene the Standards Workgroup in 2026 to develop a draft DxF roadmap for FHIR adoption for the advisory committee to review in early 2027 was carried by a vote of 16 in favor.

Questions and comments from the committee:

Advisory committee discussion included distinctions between FHIR content and data standards, FHIR APIs, and policy or governance frameworks such as TEFCA and Gravity. Members emphasized that many county and social service organizations lack funding, technical infrastructure, and vendor capacity to meet advanced interoperability requirements. Members also discussed privacy and security implications for social determinants of health data, particularly when data is shared between HIPAA-covered entities and non-covered social service organizations. Members raised concerns about CMS prior authorization API requirements and the impact of payer variation on independent practice associations, delegated entities, and provider groups. DHCS and Covered California representatives discussed federal and state policy drivers, Medicaid enterprise system funding expectations, and the need to consider diversity among plans and providers. Members recommended that the DxF roadmap for FHIR adoption promote use, not only adoption, of FHIR; align with federal timelines; include monitoring

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and measurement; consider use cases such as value-based care; consider read and write actions, and account for cost, operational capacity, and the need for long runways for smaller providers and skilled nursing facilities. Finally, members emphasized an opportunity for participants to rely on QHIOs to support FHIR requirements, as organizations build out their FHIR capacity.

Public comment:

The public commented that FHIR is the future of health data exchange, but that QHIO technical development is affected by business case and funding challenges. Commenters encouraged HCAI to avoid harm to social care and community-based organizations, include community information exchange and Gravity Project expertise, measure success based on whole person care outcomes, and consider rolling out FHIR by exchange type, starting with a proven use case such as ADT exchange.

Agenda Item V: QHIO Program

Jacob Parkinson, DxF Program Director

Robert M. Cothren, PhD, Data Exchange Framework Consultant

Following lunch, Dr. Sayles reestablished quorum. Mr. Parkinson introduced the QHIO Program discussion and explained that the item began a series of meetings dedicated to QHIO Program issues and recommendations to strengthen the program. He stated that the June meeting would focus on program issues and event notification, the August meeting would focus on alternatives and recommendations to address event notification issues, the October meeting would review recommendations related to other aspects of the QHIO Program, and the December meeting would review and discuss implementation plans.

Mr. Parkinson described the two goals of the QHIO Program: to create a statewide network for exchange and to help participants meet their data sharing obligations. He reviewed the history of the program, including development of QHIO criteria and requirements in early 2023, the August 2023 application process, reliance on attestations due to time and resource constraints, selection of nine QHIOs in October 2023, and weekly program meetings to establish connections and address implementation issues.

Mr. Parkinson assessed the current state of the program, noting that while progress has been made, the QHIO Program has not fully achieved its primary goals. He noted that QHIOs support requests for information for treatment purposes, but not for other

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purposes such as payment, operations, or public health; do not support information delivery between QHIOs; and only partially support event notification. Service gaps were also identified, including that some QHIOs do not offer services to all DxF participant types or support all data types, such as claims, behavioral health, or social services data.

Mr. Parkinson identified six QHIO Program issue areas: sustainability, service gaps, reciprocity, trust, voluntary adoption, and oversight limitations. He framed these as systemic program challenges that affect the program's ability to support statewide data exchange and help participants meet their data sharing obligations.

Questions and comments from the committee:

Advisory committee members asked questions about information delivery, participants that do not use a QHIO, and how issues are reported to HCAI. Members noted that the QHIO Program has been valuable for Medi-Cal and safety-net data exchange and emphasized that QHIOs are central to the success of the DxF, while also noting that the program design may require adjustment and refinement. Members discussed the importance of understanding use cases, patient impact, cost, trust, and the ability of social service organizations and counties to participate, highlighting challenges for small clinics to participate due to funding constraints. Members also discussed whether the QHIO Program should distinguish between common governance expectations and required service offerings, and whether QHIOs must provide the same services or could specialize. Members from community health center and county perspectives highlighted challenges related to workflow integration, data usability, completeness, timeliness, and resources required to operationalize data.

Public comment:

Because of the importance of the topic, public comment was taken before and after committee discussion. Public commenters discussed the stated goals of the QHIO Program, concerns about self-attestation, variability in QHIO capabilities, and the importance of sustainability for a statewide network. Members of the public emphasized concerns about reciprocity, noting that select QHIOs take advantage of others, and offered solutions to correct for the imbalance. Commenters encouraged HCAI and the committee to consider nonprofit intermediaries and "QHIO equivalents," county-level ecosystems, and 211 participation. Commenters also raised concerns regarding interruptions to ADT event notification exchange between QHIOs, patient safety, and the need for a process for resolving technical and compliance issues. Additional public

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comment emphasized the importance of recognizing non-QHIO intermediaries, particularly for skilled nursing facilities, and noted that trust concerns extend to participants and DSA signatories broadly.

Agenda Item VI: QHIO Program Issues Impacting Event Notification

Jacob Parkinson, DxF Program Director

Robert M. Cothren, PhD, Data Exchange Framework Consultant

Mr. Parkinson introduced the agenda item as a focused conversation on event notification and its role in California's data exchange landscape. He explained that event notification was selected because it illustrates all six QHIO Program issue areas discussed earlier: sustainability, service gaps, reciprocity, trust, voluntary adoption, and oversight limitations. He reviewed the DxF goal of enabling a common statewide system that delivers timely health event notifications to authorized DxF participants to improve care coordination and whole person care and noted the phased approach beginning with hospital admissions and discharges, then skilled nursing facilities, and later other health and non-health events.

Dr. Cothren reviewed event notification requirements under the Technical Requirements for Exchange Policy and Procedure. He explained that event notifications are currently limited to admissions and discharges and must include a minimum data set to understand the event. Hospitals and emergency departments must support HL7 v2 ADT messages and requests for notifications through rosters, while other methods may be used if mutually agreed upon. Requests must include the requesting organization and required purpose, which is required by August 1, 2026. Skilled nursing facilities are encouraged, but not yet required, to send notifications.

Dr. Cothren described three event notification patterns: direct exchange between a participant and a hospital, emergency department, or skilled nursing facility; use of the same QHIO by the source and recipient; and use of different QHIOs by the source and recipient, which requires QHIO-to-QHIO exchange. He also reviewed the operational burden of statewide event notification, including that hospitals or their intermediaries may need to manage requests from hundreds or thousands of participants, match daily events in real time, and send notifications to requesting participants.

Dr. Cothren described data sources used to assess event notification impacts, including Participant Directory data, QHIO measurement reports, participant survey responses, contract reporting, and stakeholder interviews. He then reviewed event notification from the perspective of sources, recipients, and QHIOs. For sources, approximately 80

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percent of acute care settings voluntarily use a QHIO to send event notifications, about 25 percent of those use a QHIO only for event notifications, and the majority of acute care settings using a QHIO use four QHIOs. For recipients, 45 percent of participants are receiving notifications, an additional 40 percent are interested but do not yet have capability, 65 percent of participants receiving notifications are interested in statewide notifications, and only 55 percent are satisfied with the notifications they receive. For QHIOs, Dr. Cothren reported that QHIOs collectively receive more than 90 million ADT messages quarterly and send approximately 20 million event notifications quarterly, while only about one-third of QHIO-to-QHIO connections to share rosters and events are active.

Dr. Cothren summarized how sustainability, service gaps, reciprocity, trust, voluntary adoption, and oversight limitations appear across the event notification ecosystem and contribute to complexity for sources, recipients, and QHIOs. He illustrated that a participant seeking statewide notifications may need to submit rosters to and receive notifications from more than 90 separate entities, while a hospital providing statewide notifications may need to accept and process rosters and send notifications to more than 900 separate entities, depending on QHIO and non-QHIO intermediary use.

Dr. Sayles then previewed a public webinar on July 16, 2026, regarding how other states are implementing event notification. The August 20, 2026, DxF Stakeholder Advisory Committee meeting is also expected to continue the QHIO Program and event notification discussion, including discussion of other state approaches, recommendations from the 2025 Technical Advisory Committee, and potential recommendations to address QHIO Program issues.

Questions and comments from the committee:

Advisory committee members asked what percentage of hospitals have signed the DSA and noted that presentation data did not fully align with concerns heard from independent physicians regarding barriers to receiving ADT notifications. Mr. Parkinson indicated that a majority of hospitals have signed the DSA and estimated that approximately 91 percent of general acute care hospitals have signed. Members discussed ADT notification volumes, imbalance between outbound and inbound exchanges, costs associated with processing and forwarding notifications, whether recipients are acting on notifications, and whether organizations should receive data they do not need. Members also discussed QHIO business models, whether QHIOs are required to demonstrate capabilities even when those capabilities do not align with their customer base, and the forthcoming requirement that requests include the name of the requesting organization and purpose. Members discussed roster-based and attribution-

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based approaches, large roster burden, cost, duplicate notifications, alert fatigue, and variation by provider type and region. Members also discussed the role of non-QHIO intermediaries, the need to keep implementation realities in view, and whether the identified issues result from lack of requirements, limited oversight and compliance mechanisms, resource constraints, or gaps in original program design.

Public comment:

Public comment on this agenda item focused on the importance of maintaining access to ADT event notifications while addressing the operational, technical, and policy challenges identified during the discussion. Commenters emphasized that most DxF event notification exchange currently occurs through QHIOs but noted that not all hospitals send ADTs through a QHIO and that non-QHIO intermediaries also play an important role in supporting exchange. Commenters also characterized the challenges as primarily business, policy, and funding issues rather than purely technical issues, and encouraged HCAI and the Advisory committee to consider flexible approaches that account for provider needs, participant readiness, and the cost of sustaining event notification services. Commenters also highlighted the need for clearer expectations around QHIO-to-QHIO exchange, including how ADT notifications should be treated, how technical or compliance concerns should be resolved, and how to avoid disruptions that could affect patient care. Additional comments encouraged the committee to keep non-QHIO intermediaries in mind when considering future event notification requirements and to recognize gaps that may affect participants relying on those intermediaries.

Agenda Item VII: General Public Comment

There was no general public comment at the close of the meeting.

Agenda Item VIII: Closing Remarks & Adjournment
Dr. Jennifer Sayles, Committee Chair

Dr. Jennifer Sayles, Committee Chair, thanked members and attendees for their participation and noted that the advisory committee is scheduled to meet next on August 20, 2026. Preliminary topics include QHIO Program evolution and solutions to QHIO Program issues impacting event notification; public accountability and enforcement; and individual-level demographic data and health-related social needs data.

The meeting was adjourned at 3:48 p.m.