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NOTICE OF PUBLIC MEETING

Data Exchange Framework (DxF) Stakeholder Advisory Committee Meeting #3

August 20, 2026
Draft 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; Yvonne Choong, California Association of Health Facilities; Aaron Goodale, MedPOINT Management; Katie Heidorn, California Health Care Foundation; Andrew Kiefer, Blue Shield of California; Ali Modaresi, LANES; Lucy Saenz, California Primary Care Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN); Julie Silas, Homebase.

DxF Stakeholder Advisory Committee Ex Officio Members Attending In-Person: Amanda Levy, California Department of Managed Health Care (DMHC); Janna Lowder-Blanco, California Department of State Hospitals (DSH); Shannon Rohall, California Department of Social Services (DSS); Dr. Linette T. Scott, California Department of Health Care Services (DHCS); Jared Shinabery, California Public Employees' Retirement System (CalPERS).

Attending Virtually: Rebecca Fisher, California Department of Public Health (CDPH); Dr. Scott MacDonald, UC Davis Health; Eric Nielson, County Welfare Directors Association of California (CWDA); Mark Savage, Savage & Savage LLC; Charles Raya on behalf of Taylor Priestley, Covered California.

Members Not in Attendance: Elizabeth Basnett, California Emergency Medical Services Authority (EMSA); David Ford, CMA Physician Services Organization; Ann M. Nakamura, California Department of Developmental Services (DDS); Lee Tien, Electronic Frontier Foundation.

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; Cary Sanders, Senior Policy Director, CPEHN; Ignatius Bau, Policy Consultant, CPEHN; Camey Christenson, Chief Business Development Officer, 211/CIE San Diego; Alana



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Kalinowski, Interoperability Solutions Architect, 211/CIE San Diego; Dr. Brian Thomas, Director of Social Health Information Exchange, Alameda County Health.

Public Attendance: A total of 47 public attendees.

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

Dr. Jennifer Sayles, Committee Chair, called the meeting to order, 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 June 18, 2026, DxF Stakeholder Advisory Committee meeting. Mark Savage, Savage & Savage LLC, motioned to approve the minutes, and Lucy Saenz, California Primary Care Association, 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 June 18, 2026, meeting minutes: Dr. Jennifer Sayles (Chair), Joan Allen, William Barcellona, Colleen Chawla, Yvonne Choong, Aaron Goodale, Katie Heidorn, Andrew Kiefer, Dr. Scott MacDonald, Ali Modaressi, Eric Nielson, Lucy Saenz, Mark Savage, Kiran Savage-Sangwan, and Julie Silas.

David Ford and Lee Tien were absent from voting.

The motion to approve the June 18, 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

Elizabeth Landsberg, Director, provided department updates relevant to the advisory committee's work and reviewed several items included in the newly enacted state budget. She highlighted funding to support gender-affirming care and reproductive



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health care and Behavioral Health Services Act workforce investments. She also highlighted the continued implementation of the CalRx Program. She noted that California would provide free albuterol inhalers and spacers to schools and that future CalRx products are expected to include epinephrine auto-injectors and tuberculosis medications. She also noted ongoing funding for the Health Care Payments Data (HPD) Program was authorized in the 2026 State Budget and that the program plans to begin collecting data from pharmacy benefit managers.

Director Landsberg also discussed support for financially distressed hospitals, including an additional \$90 million for grants and \$10 million to establish a new HCAI health care stability unit. She described the unit as supporting evaluation of hospitals' strategic importance to their communities, planning to maintain critical services in the event of financial distress, and providing technical assistance for distressed hospitals.

Director Landsberg provided an update on the Rural Health Transformation Program, noting California's \$233.6 million award under the national \$50 billion program and the rollout of Requests for Applications across various initiatives. She also highlighted HCAI's engagement with rural and Tribal communities, including a five percent Tribal set-aside, which she described as a floor, and the first meeting of the Rural Health Policy Council.

Questions and comments from the committee:

Advisory committee members recognized the importance of ongoing funding for the HPD Program and its value as a statewide all-payer claims database. Members also asked how HCAI is tracking the potential impact of wildfires on Tribal nations and other rural communities. Director Landsberg noted that HCAI is aware of the impacts, is continuing to listen to rural and Tribal partners, and will consider how climate-related impacts may affect priorities such as primary care, chronic disease management, and maternity care.

Public comment:

A member of the public raised concerns about federal efforts to access state health care databases and the protection of sensitive health information in California.

Agenda Item III: HCAI DxF Program Updates and Future Discussion Topics

Michael Valle, Assistant Director

Jacob Parkinson, DxF Program Director



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Michael Valle, Assistant Director, reviewed the advisory committee's discussion roadmap through April 2027, and the two SB 660 workstreams requiring committee input: recommendations for HCAI's July 2027 legislative report and recommendations related to the collection of individual-level demographic and health-related social needs (HRSN) data. He noted that the August meeting would begin the HRSN current-state discussion and continue discussion of the Qualified Health Information Organization (QHIO) Program Evolution, with additional work on both topics and public accountability and enforcement planned for October.

Mr. Valle also reviewed next steps following the committee's June vote to convene a technical workgroup on Fast Healthcare Interoperability Resources (FHIR) technical standards adoption. Jacob Parkinson, DxF Program Director, noted that HCAI expects to select approximately 15 members with practical technical and operational FHIR implementation experience for the 2026 Standards Workgroup. The workgroup is expected to meet virtually six to eight times, beginning in October 2026 and advise on priority use cases, adoption strategies, cost mitigation, transition from legacy standards, and an overall adoption timeline. Applications are due August 31, 2026, and HCAI expects to bring a draft DxF Roadmap for FHIR Adoption to the committee in spring 2027.

Mr. Parkinson provided updates on public accountability and enforcement. He previewed a substantive amendment to the Participant Directory Policy and Procedure to clarify when Participants that delayed exchange must update their Participant Directory selections. He noted that the amendment would be subject to a 45-day public comment period and, once finalized, a 180-day implementation period. He also previewed forthcoming Frequently Asked Questions clarifying which clinics are required to sign the Data Sharing Agreement (DSA) and that an organization may not execute the DSA on behalf of a contracted organization that is itself a required signatory.

Mr. Parkinson also reviewed recent DSA signing activity and accountability requirements. He noted that 528 entities signed the DSA between June 1 and July 14, 2026; that SB 164 extended the deadline to execute the DSA and begin exchanging to July 1, 2027, for specified community, intermittent, and rural health clinics; and that HCAI must begin publishing a list of known noncompliant required signatories on January 1, 2027. He described the Required DxF Signatory Methodology, the Non-Required Signatory Attestation, the Statement of Extenuating Circumstances, related Standard Operating Procedures, and a phased, multi-channel outreach campaign to unsigned entities planned through the end of 2026.



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Questions and comments from the committee:

Advisory committee members emphasized that accountability efforts should support not only execution of the DSA but also meaningful use of the DxF. Members asked HCAI to clarify the education process for organizations after they sign. HCAI described compliance as a progression from signing the DSA, to connecting with appropriate technology or intermediary partners, to exchanging information in accordance with DxF requirements, and noted that current outreach is focused on making entities aware of both the requirement to sign and the obligations that follow signing.

Public comment:

A member of the public asked HCAI to clarify the distinction between entities that are not required to sign the DSA and voluntary signatories, including whether the distinction is clearly reflected in the DxF Policies and Procedures.

Agenda Item IV: Individual-Level Demographic Data and Health-Related Social Needs (HRSN) Data

Jacob Parkinson, DxF Program Director

Cary Sanders, Senior Policy Director, CPEHN

Ignatius Bau, Policy Consultant, CPEHN

Camey Christenson, Chief Business Development Officer, 211/CIE San Diego

Alana Kalinowski, Interoperability Solutions Architect, 211/CIE San Diego

Dr. Brian Thomas, Director of Social Health Information Exchange, Alameda County Health

Mr. Parkinson introduced the agenda item as the first in a series of discussions intended to inform the advisory committee's SB 660 recommendations regarding the collection of individual-level demographic and HRSN data. He emphasized the distinction between collection and exchange: current DxF requirements generally establish expectations for the exchange of information that a Participant maintains and may legally share, but do not require Participants to collect demographic or HRSN data they do not otherwise maintain or to use a single questionnaire, screening tool, or workflow.

Mr. Parkinson reviewed the current standards environment, including United States Core Data for Interoperability version 3 elements related to race, ethnicity, Tribal affiliation, sex, sexual orientation, gender identity, preferred language, disability status, and social determinants of health. He noted that federal standards related to sexual



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orientation and gender identity continue to evolve. HCAI proposed using the August meeting to establish the current-state landscape, the October meeting to develop and discuss potential recommendations and implementation considerations, and the December meeting to refine and formally vote on proposed recommendations.

Cary Sanders of the California Pan-Ethnic Health Network (CPEHN) presented themes from key informant interviews conducted by CPEHN and their consultant, Ignatius Bau, with purchasers, health plans, hospitals, clinics and physician practices, and community-based health and social services organizations. Interviewees generally supported demographic and HRSN data collection and exchange, with race and ethnicity data described as the most complete and language data next most complete. CPEHN reported that sexual orientation and gender identity data collection remains incomplete, disability data collection is limited, and organizations are increasingly concerned about privacy, resource constraints, federal inquiries, immigration enforcement, transgender health care, and the use and ownership of data. CPEHN also noted uneven understanding and use of data exchange, particularly among small physician practices and social services organizations.

Mr. Parkinson then reviewed selected 2024 California data from the American Board of Family Medicine Continuous Certification Questionnaire. Among 1,158 California family medicine physician respondents, 56 percent reported often or sometimes documenting HRSN screening in a clinical note, compared with 35 percent using diagnosis codes and 25 percent using a structured box or button in the electronic health record. HCAI noted that unstructured documentation may make HRSN information more difficult to standardize and exchange.

Camey Christenson and Alana Kalinowski of 211/Community Information Exchange (CIE) San Diego described the CIE model, an opt-in, locally governed approach that uses shared language, role-based permissions, bidirectional referrals, interoperable technology, and a longitudinal record to support cross-sector care coordination. They described a network of approximately 1,300 licensed users across 141 organizations and approximately 18 integrations with health care, social service, housing, payer, and other source systems. They highlighted the Homeless Management Information System (HMIS) integration, use of status-change alerts and shared assessments, and the importance of translating and mapping information across systems so that exchanged data are actionable. Recommendations from the field included improved access to state benefits and enrollment data, consent and need-to-know frameworks, and minimum data sets that provide sufficient information for effective referrals and care coordination.



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Dr. Brian Thomas of Alameda County Health described Alameda County's Social Health Information Exchange implementation and the opportunity to use integrated HRSN data not only for individual care coordination but also for service planning across programs and geographies. He described efforts to bring data from multiple county programs into a more standardized framework and identified consent complexity, cross-departmental data silos, governance, response times, and the need for consistent standards that can support real-time exchange as key implementation considerations.

Questions and comments from the committee:

Advisory committee members discussed the practical challenge of making demographic and HRSN information usable across numerous organizations, electronic health records, and community-based systems. Members asked how information such as current housing status can be made available to care teams in a timely and actionable format when organizations use different systems and documentation practices. Discussion highlighted the role of CIEs and other intermediaries in translating and mapping structured and unstructured information across systems, and the importance of establishing common standards without requiring every organization to use the same technology.

Members discussed Department of Health Care Service's (DHCS) Medi-Cal Connect population health management tool as an example of bringing together Medi-Cal information with other data sources, including homelessness, immunization, vital records, and foster care information. DHCS clarified that Medi-Cal Connect is a population health management platform rather than a health information exchange and described opportunities to enrich it over time with additional clinical information. Discussion also focused on the urgent value of timely Medi-Cal renewal or redetermination information for organizations conducting outreach to people who may be affected by H.R.1 and upcoming eligibility changes. Members noted that existing aid-code and eligibility infrastructure may require transition time as those changes are implemented.

Advisory committee members also emphasized privacy and appropriate-use safeguards for sensitive demographic and HRSN information. Members cited information about people experiencing homelessness, immigration-related information, disability or functional status, and other social needs as examples where a "need to know" approach may be important. The discussion emphasized balancing the value of sharing information for whole-person care and proactive outreach with the risk of disclosure or misuse.



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Dr. Sayles noted that a clear theme emerging from the discussion was the urgency of supporting populations affected by H.R.1 and identified this as an important consideration for the Committee's future work on demographic and HRSN data.

Public comment:

A member of the public commented in support of greater state data contributions for care coordination, including timely access to Medi-Cal renewal or redetermination information.

A member of the public also highlighted a publicly available minimum-data-set resource developed through Providing Access and Transforming Health (PATH) Collaborative Planning and Implementation work.

A member of the public encouraged California to align future HRSN data collection and exchange recommendations with the Gravity Project and other national standards rather than create a parallel California-specific approach.

Agenda Item V: Qualified Health Information Organization (QHIO) Program Evolution
Part 1

Jacob Parkinson, DxF Program Director

Robert M. Cothren, PhD, Data Exchange Framework Consultant

Following lunch, Dr. Sayles reestablished quorum. Mr. Parkinson recapped the two goals of the QHIO Program: supporting statewide exchange of health and social services information (HSSI) and helping Participants meet DxF requirements. He also reviewed the six QHIO Program issues identified at the June meeting: sustainability, service gaps, reciprocity, trust, voluntary adoption, and oversight limitations. Mr. Parkinson noted that the discussion would review potential solutions, with the Committee expected to continue the discussion and vote on recommendations in October and consider implementation approaches in December.

Dr. Cothren reviewed approaches used by other states and by the Trusted Exchange Framework and Common Agreement (TEFCA). He contrasted centralized statewide services with distributed models, state-operated services with independent intermediaries, state-funded models with participant-funded models, and approaches that require use of designated intermediaries with California's model. He noted that California is not unusual in using multiple independent exchange organizations but is unusual in not requiring use of designated intermediaries. Other state approaches reviewed included minimum operating thresholds, qualification by exchange type,



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required use of designated services, participant verification, and more prescriptive technical and operational standards.

Dr. Cothren also reviewed how those approaches relate to the six QHIO Program issues. He noted that required use and minimum operating thresholds can support sustainability and reciprocity; statewide or exchange-type-specific service models can reduce service gaps; verification processes can strengthen trust; and common standards and testing can improve oversight. He also reviewed current adoption patterns, noting that QHIO use varies by exchange type and that some Participants instead rely on nationwide networks, point-to-point connections, or other intermediaries.

Mr. Parkinson then invited the Committee to discuss which approaches used by other states or organizations appeared to have the greatest potential for the DxF and whether HCAI should consider additional approaches. He explained that this discussion was intended to remain at a high level and inform the more specific potential solutions the Committee would consider after the break.

Mr. Parkinson then described the first of two actions HCAI intends to take to address QHIO Program issues: establishing QHIO-to-QHIO exchange standards through QHIO Program modifications and, potentially, revisions to existing administrative regulations. He explained that the Program has historically relied largely on standards voluntarily agreed upon by QHIOs and that HCAI now intends to establish a required baseline for inter-QHIO exchange. The standards are intended to strengthen statewide exchange, address roster and event-sharing challenges, reduce Program ambiguity, and improve oversight, while allowing innovation above the required floor.

Mr. Parkinson also described a second planned action, referred to as "Voluntary Exchange During Participant Verification." Under this approach, QHIOs and other Participants would be permitted to suspend exchange of HSSI with a signatory while HCAI determines through Participant Verification whether the organization is a legitimate health or social service organization, governmental agency, or vendor. Participants would remain required to respond to verified DxF Participants for Required Purposes when permitted by law; could choose whether to respond to non-Participants or organizations undergoing verification; and should not respond under the DxF to organizations that fail verification. HCAI noted that implementation would likely require amendments to the Requirement to Exchange HSSI Policy and Procedure and the Participant Verification Standard Operating Procedure, and that regulations may also be explored as needed.



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Questions and comments from the committee:

Advisory committee members discussed the balance between statewide consistency and the value of California's regional and locally developed exchange infrastructure. Members noted that common minimum standards could function as a floor while still allowing innovation above that floor, and several members emphasized preserving local care-coordination strengths while establishing consistent statewide expectations. Members also discussed whether demographic and social services information should be considered more explicitly when assessing QHIO service gaps, the importance of standardized and usable data sets for health plans and providers, and the potential for QHIO infrastructure to support additional public and social-service use cases when needed data are made available.

Members discussed the risks of maintaining the current structure without additional changes, including the need for Participants to work with multiple QHIOs or intermediaries to achieve statewide coverage, uneven reciprocity, service gaps, and limitations in HCAI's ability to oversee performance and corrective action. Members also asked about the timeline for meaningful program changes and how QHIO-to-QHIO standards would be established and enforced. HCAI noted that standards development would involve continued engagement with QHIOs to determine what is feasible and appropriate for Participants and that existing compliance review and corrective-action processes could be applied to new requirements. Members also cautioned that Participant Verification should be implemented in a way that accommodates community-based and social service organizations with limited administrative capacity.

Public comment:

Public commenters generally supported continued evolution of the QHIO Program and stronger statewide exchange while offering different perspectives on the role of statewide versus regional infrastructure. Commenters supported clearer QHIO-to-QHIO standards, including consideration of FHIR Application Programming Interface (API)-based approaches for event notification, and highlighted California's inclusion of fire and emergency medical services in interoperability requirements. Commenters emphasized that QHIOs primarily move data rather than house all available information, encouraged recognition of the Program's relative maturity compared with longer-standing state Health Information Exchange (HIE) efforts, and noted that Participant Verification is a broader DxF issue that extends beyond the QHIO Program. Commenters also offered differing perspectives on national networks: some highlighted their ability to support



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reciprocity and exchange at scale, while others noted limitations including geofencing and patient-matching challenges that QHIOs may be able to address locally.

Agenda Item VI: QHIO Program Evolution Part 2

Jacob Parkinson, DxF Program Director

Robert M. Cothren, PhD, Data Exchange Framework Consultant

Mr. Parkinson introduced the first two potential solutions for further advisory committee consideration. The first would require a minimum operating threshold, under which a QHIO would need to demonstrate a minimum volume of existing business when seeking qualification for an exchange type. HCAI presented this approach as a way to provide market-based evidence of capability, reduce imbalances in investment and reciprocity, and improve oversight, while noting that threshold design would require careful consideration and could make qualification more difficult for new or smaller organizations.

The second potential solution would allow QHIOs to specialize by choosing the DxF exchange types for which they seek qualification. HCAI noted that specialization could allow QHIOs to focus investments on services aligned with their business models and strengths but could also reduce the number of QHIOs that meet all of a Participant's needs and require some Participants to switch QHIOs or use more than one QHIO.

Questions and comments from the committee:

The advisory committee discussed the minimum operating threshold and specialization solutions together before the first two polls. Many members expressed interest in a minimum operating threshold and emphasized the value of demonstrating actual capability rather than relying solely on attestations. At the same time, members asked how thresholds would be defined and applied, whether different thresholds would be needed by exchange type or service, and how the approach could affect smaller, newer, nonprofit, or regionally focused QHIOs. Members also emphasized that a threshold should reflect the quality and usefulness of services from the end-user perspective, not simply volume or technical capability.

Discussion of specialization focused on the potential for additional fragmentation, Participant confusion, and the need to contract with multiple QHIOs for different services. Members asked how specialization would interact with minimum operating thresholds and whether QHIOs might specialize by exchange type, provider market, or service category. Members requested a clearer picture of the existing QHIO landscape, including which QHIOs serve which provider types and exchange services, and



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emphasized the need to assess provider costs and other unintended consequences before the October discussion.

Several members raised the question of what the cost impact to healthcare providers, health plans, and government payors would be of these decisions.

Public comment:

Public comment was then taken on both the minimum operating threshold and specialization solutions before the first two Fist-to-Five polls. Commenters generally supported the concept of minimum operating thresholds but emphasized that the level and design of the threshold would be important, including its relationship to reciprocity and cost recovery. Commenters expressed mixed views on specialization: some saw value in allowing QHIOs or other intermediaries to focus on selected services, while others warned that specialization could increase fragmentation and require Participants to contract with multiple QHIOs.

Nonbinding Fist-to-Five Poll – Require Minimum Operating Threshold:

The Committee then conducted the first nonbinding Fist-to-Five poll to help HCAI understand members' current directional support and identify issues requiring further discussion before October. A score of 0 indicated no support and a score of 5 indicated enthusiastic support. The exercise was described as a poll rather than a formal vote. Responses were collected from voting members and participating ex officio members.

Voting members - Require Minimum Operating Threshold: Joan Allen (4); William Barcellona (5); Colleen Chawla (5); Yvonne Choong (3); David Ford (not present); Aaron Goodale (5); Katie Heidorn (4); Andrew Kiefer (5); Scott MacDonald (not present); Ali Modaressi (5); Eric Nielson (4); Lucy Saenz (4); Mark Savage (1); Kiran Savage-Sangwan (3); Jennifer Sayles (4); Julie Silas (3); Lee Tien (not present).

Ex officio members - Require Minimum Operating Threshold: Elizabeth Basnett (not present); Rebecca Fisher (not present); Amanda Levy (4); Janna Lowder-Blanco (not present); Ann M. Nakamura (not present); Charles Raya on behalf of Taylor Priestley (4); Shannon Rohall (4); Linette T. Scott (5); Jared Shinabery (4).

Of 14 voting members who participated, five responded 5, five responded 4, three responded 3, and one responded 1; no voting members responded 0 or 2. Five ex officio members also participated, with four responding 4 and one responding 5.



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Nonbinding Fist-to-Five Poll – Allow QHIOs to Specialize:

Voting members - Allow QHIOs to Specialize: Joan Allen (2); William Barcellona (3); Colleen Chawla (1); Yvonne Choong (2); David Ford (not present); Aaron Goodale (1); Katie Heidorn (2); Andrew Kiefer (1); Scott MacDonald (not present); Ali Modaresi (1); Eric Nielson (2); Lucy Saenz (4); Mark Savage (1); Kiran Savage-Sangwan (1); Jennifer Sayles (1); Julie Silas (0); Lee Tien (not present).

Ex officio members - Allow QHIOs to Specialize: Elizabeth Basnett (not present); Rebecca Fisher (not present); Amanda Levy (3); Janna Lowder-Blanco (not present); Ann M. Nakamura (not present); Charles Raya on behalf of Taylor Priestley (2); Shannon Rohall (2); Linette T. Scott (3); Jared Shinabery (1).

Of 14 voting members who participated, one responded 0, seven responded 1, four responded 2, one responded 3, and one responded 4; no voting members responded 5. Five ex officio members participated, with one responding 1, two responding 2, and two responding 3.

Mr. Parkinson then presented the third potential solution, which would require Participant use of QHIO services in selected circumstances. HCAI described this as a possible way to reduce fragmentation, improve statewide coverage, and support QHIO sustainability, while noting that it could limit choice, create new costs or contracting requirements, require pricing considerations, and potentially require statutory change. HCAI emphasized that the concept could apply only to selected Participant types or exchange services rather than requiring all Participants to use QHIOs for every form of exchange.

Questions and comments from the committee:

Before the third poll, the advisory committee discussed the proposed requirement for Participant use of QHIO services. Members emphasized the importance of clearly defining the problem being solved and avoiding a one-size-fits-all requirement. Discussion considered whether required use might be appropriate for selected Participant types or exchange services, including event notification, while allowing other forms of exchange to continue through existing pathways. Members raised questions about onboarding capacity, vendor changes, existing point-to-point or national-network connections, and cost implications for Participants. Mr. Parkinson clarified that the concept was being presented directionally and was not intended to require all Participants to use a QHIO for every exchange type.



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Public comment:

Public comment was then taken on the proposed requirement for Participant use of QHIO services before the third Fist-to-Five poll. Members of the public raised concerns about limiting providers' ability to use existing non-QHIO intermediaries, potential unfunded mandates, and the cost implications of a new requirement. Other commenters supported a targeted requirement for high-priority statewide use cases such as hospital admission, discharge, and transfer event notification. Commenters also urged HCAI to consider the potential effects of future requirements on nonprofit QHIOs and the existing exchange ecosystem.

Nonbinding Fist-to-Five Poll – Require Participant Use of QHIO Services:

After committee discussion and public comment, the Committee conducted the third nonbinding Fist-to-Five poll on requiring Participant use of QHIO services.

Voting members - Require Participant Use of QHIO Services: Joan Allen (3); William Barcellona (1); Colleen Chawla (3); Yvonne Choong (0); David Ford (not present); Aaron Goodale (5); Katie Heidorn (5); Andrew Kiefer (5); Scott MacDonald (2); Ali Modaresi (5); Eric Nielson (not present); Lucy Saenz (3); Mark Savage (4); Kiran Savage-Sangwan (4); Jennifer Sayles (4); Julie Silas (2); Lee Tien (not present).

Ex officio members - Require Participant Use of QHIO Services: Elizabeth Basnett (not present); Rebecca Fisher (3); Amanda Levy (3); Janna Lowder-Blanco (not present); Ann M. Nakamura (not present); Charles Raya on behalf of Taylor Priestley (3); Shannon Rohall (not present); Linette T. Scott (3); Jared Shinabery (2).

Of 14 voting members who participated, one responded 0, one responded 1, two responded 2, three responded 3, three responded 4, and four responded 5. Five ex officio members participated, with one responding 2 and four responding 3.

Additional questions and comments from the committee:

Following the three polls, advisory committee members identified additional approaches for HCAI to research before the October meeting. Suggestions included funding QHIOs to strengthen common service levels; enacting territorial boundaries within which QHIOs are allowed to operate, incentives or subsidies for statewide coverage; research focused on specific high-value use cases such as shared care planning; a Regional Extension Center-like model to concentrate implementation support; closer examination of how other states integrate social services data; assessment of QHIO onboarding capacity and readiness; and cost mitigation or incentive structures for smaller Participants. Committee members also encouraged HCAI to keep future



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recommendations technology-agnostic and adaptable as standards and national networks evolve, and to consider whether geography or market structure could provide a more deliberate organizing principle for the QHIO Program.

Public comment:

No additional public comment was offered after the Committee's discussion of other potential solutions.

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

The meeting concluded with thanks to members and attendees for their participation and a reminder that the advisory committee is scheduled to meet next on October 15, 2026, with additional meetings scheduled for December 17, 2026, February 18, 2027, and April 15, 2027. Preliminary topics for Meeting #4 include public accountability and enforcement, continued discussion of QHIO Program evolution and a vote on potential solutions, and collection of individual-level demographic and HRSN data.

The meeting was adjourned at 3:55 p.m.