Trusted Exchange Framework and Common Agreement Task Force

Transcript
May 24, 2019
Virtual Meeting

SPEAKERS

Name	Organization	Role
Arien Malec	**Change Healthcare**	**Co-Chair**
John Kansky	**Indiana Health Information Exchange**	**Co-Chair**
Noam Arzt	HLN Consulting, LLC	Public Member
Laura Conn	Centers for Disease Control and Prevention (CDC)	Member
Cynthia A. Fisher	WaterRev, LLC	Member
Anil K. Jain	IBM Watson Health	Member
David McCallie, Jr.	Individual	Public Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Carolyn Petersen	Individual	Member
Steve L. Ready	Norton Healthcare	Member
Mark Roche	Centers for Medicare and Medicaid Services (CMS)	Member
Mark Savage	UCSF Center for Digital Health Innovation	Public Member
Sasha TerMaat	Epic	Member
Grace Terrell	Envision Genomics	Public Member
Andrew Truscott	Accenture	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Denise Webb	Individual	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator	HITAC Back Up/Support
Zoe Barber	Office of the National Coordinator	Staff Lead
Kim Tavernia	Office of the National Coordinator	Back Up/Support
Alex Kontur	Office of the National Coordinator	SME

Morris Landau	Office of the National Coordinator	Back-up/Support
Michael Berry	Office of the National Coordinator	SME
Debbie Bucci	Office of the National Coordinator	SME
Kathryn Marchesini	Office of the National Coordinator	Chief Privacy Officer

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you. Good afternoon, everyone. Welcome to the TEFCA Task Force meeting. This is our fourth meeting in the series. Let's get started, and I will officially begin by taking roll. John Kansky?

John Kansky - Indiana Health Information Exchange - Co-Chair
I am here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Arien Malec.

Arien Malec – Change Healthcare – Co-Chair
Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning. Carolyn Petersen?

Carolyn Petersen - Individual -Member
Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning. Aaron Miri? Sheryl Turney?

Sheryl Turney - Anthem Blue Cross Blue Shield - Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sasha TerMaat?

Sasha TerMaat - Epic - Member
Good morning. Steve Ready? Cynthia Fisher? Anil Jain?

Anil K. Jain - IBM Watson Health - Member
I'm here. Phone only.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, thank you. Andrew Truscott?

Andrew Truscott - Accenture - Member
Presence on the phone only.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you. Denise Webb? She's not here. She's on vacation. David McCallie?

David McCallie, Jr. - Individual - Public Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Mark Savage?

Mark Savage - UCSF Center for Digital Health Innovation - Public Member
Good morning. Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning. Noam Arzt? Grace Terrell and Laura Conn? Okay. Thank you very much. Arien?

Arien Malec - Change Healthcare - Co-Chair
All right, as we discussed yesterday, we got through the majority of the MRTCs, as well as the QTF. That really represents the major updates of TEFCA 2 from TEFCA 1, and we wanted to prioritize today the key questions that came out of that broad level overview that we should be discussing as a group so that we can formulate recommendations. What we are going to do right now is do a presentation on what we heard out of the task force that were the key questions that required discussion as well as the proposed prioritization of those key questions. And in the first part of this call, we really want to make sure that from the task force, first of all, we represented that list correctly and that we represented the priorities correctly because that will basically serve as the work plan for the next stage of our discussion. I guess the other thing that I want to update the group on is that we've gone back to ONC leadership on the timeframe for the task force.

There are two advisory committee meetings: one in June on June 19th and the other on July 11th. We've proposed - but have not yet been granted an extension - to have us target June 19th to do draft recommendations and July 11th to do final recommendations. But I think we recognize that the Cures NPRM and information blocking work that a number of us had been participating in has been taking appropriate precedents over the TEFCA task force work. So, we are really starting in earnest and most likely need more time. So, just reassure people that that request is in. Whether it will be granted or not is a different question. John, anything you want to add?

John Kansky - Indiana Health Information Exchange - Co-Chair

Let me just quickly ask is anybody on the call today that missed the call yesterday?

Male Speakers

Yes. Yes.

John Kansky - Indiana Health Information Exchange - Co-Chair

Let me make sure this makes sense to you. Arien just said it, but I'm just making sure, especially since a couple of you guys, Anil and Andy, are only on the phone. There is a matrix in your email that you may or may not have seen or may or may not have in front of you. That is a summary of basically yesterday. We captured the key questions for discussion by the task force kind of across, top to bottom of our charge. What we are going to do here early on the call is to try and make sure we have captured and prioritized those because as Arien said that is kind of our work plan for going forward. These are the items that will be discussed on the remainder of the call and in future calls to formulate our recommendation. So, I wanted to make sure that approach was explained and kind of sort of makes sense, and I don't know if you guys are handicapped by just being on the phone or if you can cope.

Andrew Truscott - Accenture - Member

I am handicapped by myself, John, but, no, I've already reviewed that matrix. I agree with everything that's in it, and I agree the number one thing on that list is the number one thing. Now, what are we actually seeking to do with the task?

Anil K. Jain - IBM Watson Health - Member

John, this is Anil. I will look at it later. I am traveling, and so I have not had a chance to look at it. But I will look at it hopefully during this but if not then later.

Arien Malec - Change Healthcare - Co-Chair

Importantly, at least you know what we are working on and what we are trying to accomplish and what we are talking about.

Anil K. Jain - IBM Watson Health - Member

Right. Exactly.

Arien Malec - Change Healthcare - Co-Chair

All of that being said, should we get into reviewing the matrix and making sure that we fairly represented all of the key questions and that we appropriately represented priority? We shouldn't argue about what's number one and number two. But if something is ten, and it's your number one or something is one and it's your number ten, those are things we probably should make sure we address. I think it's appropriate to then go into the matrix and make sure at this point we're not debating any of the items. We're just making sure we are entering the matrix. We're taking the blue or red pill or whatever it is. At this point, we are not debating any of the items. We are just making sure that we've got the items represented in the worksheet appropriately. Does that make sense as an exercise?

Male Speakers
Yes. Yep.

Arien Malec - Change Healthcare - Co-Chair
All right, so going down from the top of the list, our proposed tier 1 issues, number one is what are the broad goals at TEFCA? And what is economic model or incentive if you are a HIN to be a QHIN? And at least in this area, I think we proposed a tentative set of answers for this. The broad goal of the TEFCA should not just be to check the box on Congress's request of ONC to establish a test but should be to enable better treatment, quality of care, and a more efficient health system. And then also a perspective that participation in the TEF by participants who are working with HINs who become QHINs should be presumed at least to address some of the information blocking requirements.

Then we have a whole bunch of questions on applicable law. I think this is particular to yesterday's discussion on HIPAA and then the obligations on QHINs and also on participants that apply extra to HIPAA or that apply to non-HIPAA, non-covered entities or non-BA's. We want to understand and make sure that we know what applies in what situations and what conditions. And in what cases can existing obligations be deemed to meet the QHIN or TEF requirements, the MRTC requirements, and in what cases are the generally new obligations placed on actors? And we want to make sure that we aren't requiring organizations - or if we are requiring them, we understand it - to re-contract around existing obligations or to add new obligations to actors that have already established in good faith kind of appropriate activities.

There is a whole set of discussion on exchange modalities and the QTF, and in particular, is the QTF appropriately situated relative to the policy goals for the MRTCs? There are a couple of particular questions: one around broadcast query and the other around directed or push query. We should add push query to this. Number one, do we understand the functional requirements for broadcast query in the MRTC? And number two, is the QTF responsive to the broadcast query requirements? And **[inaudible] [00:10:11]** of the functional requirements for pushed or directed exchange and are the technical enablement in the QTF responsive to the functional requirements?

The next is exchange modalities and purposes. There's a lot of discussion about who needs to respond in what situations and for what purposes. And what are the obligations of the QHIN that I think are appropriate to discuss and make sure we, A, understand and, B, agree with? So, we had a discussion on individual access and the role of the individual and what is implied in exchange modalities as being permitted. What additional activities are permitted relative to applicable law? And what are the roles and responsibilities of a participant who are acting on behalf of the individual? And when are those roles part of the MRTCs? And when are they purely individual access roles? After the call yesterday, I gave the example of a mobile device vendor who enables individual access to a device and then subsequently enables the patient to make determinations about the use of data for research purposes, as differed from somebody who is engaging in access for data particularly for the purposes of research. In some cases, you are on one side of the individual access boundary. In other cases, you are on

the other.

John Kansky - Indiana Health Information Exchange - Co-Chair
Arien?

Arien Malec - Change Healthcare - Co-Chair
Yeah.

John Kansky - Indiana Health Information Exchange - Co-Chair
When there is a break, Andy has his telephonic hand raised.

Arien Malec - Change Healthcare - Co-Chair
Oh, good. Okay. Let's get through tier 1 and then bring Andy in. Let's go down. Then there is a whole discussion on meaningful choice and whether it's appropriate to exercise meaningful choice for treatment purposes. How do you exercise meaningful choice relative to sensitive information? We had a brief discussion yesterday relative to the prospective versus retrospective exercise in meaningful choice. And when is the horse already out of the barn? Is there a right to be forgotten relative to individual access and meaningful choice? Those are the proposed tier 1 items. I think Mark has his hand up, but first Andy had his telephonic hand up. So, Andy, go ahead.

Andrew Truscott - Accenture - Member
Thanks, Arien. Thanks, John. Very quickly, there is a big list in there, Arien, and I'm trying to get my head around some of the core principles of what we are seeking to achieve with TEF. You say are we creating the authorizations in here? My question is should we be creating authorizations, or should we be laying down the framework that demonstrates how obligations can be met as opposed to defining new authorizations or trying to say thou shall do it this way? Clarify that difference between what you do versus how you do it.

Arien Malec - Change Healthcare - Co-Chair
Yep. And, again, our original TEF recommendations recommended that ONC establish broad objectives, broad and clear objectives, and then delegate to the RCE and QHINs the mechanisms for achieving those. And I think ONC has listened to our recommendations and come up with what they believe is a minimal set of recommendations. I think it is appropriate for us to relook at that and ask is this really the right minimal set? Or is there a different balance that could be struck? Great point. Okay, Mark and then David.

Mark Savage - UCSF Center for Digital Health Innovation - Public Member
Yeah. Thanks, Arien. I may have missed this, but I just wanted to say on the individual access services I had a broader question about the definition of individual access, and PTHD was one example. So, that's a good placeholder as is but just flagging that it is bigger than that.

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead

I got you.

Arien Malec - Change Healthcare - Co-Chair

We have under the individual access services. Right now it is a pure query. Is there a right to update, a right to modify, and a right to add relative to individual access? I think we've got that question. Do you think it's broader than that?

Mark Savage - UCSF Center for Digital Health Innovation - Public Member

I do, but I don't need to frame it for purposes of what we are doing today. I'm just saying.

Arien Malec - Change Healthcare - Co-Chair

Yeah. You feel we have an appropriate placeholder here for discussion.

Mark Savage - UCSF Center for Digital Health Innovation - Public Member

Correct. Correct.

Arien Malec - Change Healthcare - Co-Chair

And you just want to note you can get the bigger issue. Cool. David?

David McCallie, Jr. - Individual - Public Member

I like this list a lot. And just a fine-tuning on the broad goals number one point there, which is to ensure that it is clear how the TEF integrates with the information blocking NPRM in terms of making sure there are not definitions that are out of sync or policies that force people one way or the other because of an unintended consequence in the context of the information blocking rule, it is a subpart of that incentive question. But even if you've got the incentives aligned, you could create unexpected consequences by making it preferable to do TEF over some other approach or vice versa more likely.

Arien Malec - Change Healthcare - Co-Chair

Yeah, and, again, to note right now there is no information blocking implication for being a participant who works with a HIN that's a QHIN. So, it's not even clear what obligations of information blocking you are addressing through participation in TEFCA. There was an information blocking question about whether there should be an exception related to the MRTCs themselves, although they weren't called MRTCs in the information blocking rule, but nothing that I've described as a safe lane because it's not quite a safe harbor or what have you. Anyway. Okay, I don't see anybody else's hand up. Does anybody who is phone only want to make sure that they've got their tier 1 issues addressed?

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead

Arien, can I make a quick comment on the blocking?

Arien Malec - Change Healthcare - Co-Chair

Sure. Please.

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead

I want to be sure. I know we talked to Elise and Mike about a little bit, but I just want to be sure we stay within the scope of our charge and don't get too deep into the connections between information blocking. I think we agreed we can sort of discuss it a high level, like the goals of the TEFCA as it relates.

Arien Malec - Change Healthcare - Co-Chair

Yes. No, I definitely appreciate that. We don't want to get into the mechanics of information blocking because we addressed them at a pretty detailed level. This is more making sure that if this task force believes - and maybe the task force doesn't - that participation in the TEFCA should address aspects of information blocking, that we would recommend to ONC that that connection be made clear. Anybody on the phone believe their tier 1 issues were not addressed? Let's go down to tier 2. Again, making sure this is appropriately framed and then making sure, again, are any of these tier 2 issues really tier 1 issues? You know, do we have the right broad priorities? So, number one is we had a point on the use of cloud vendor outside of the United States, and it wasn't clear in the TEFCA if I've got a data center operation that's not a cloud operation, is that the U.S. only?

And then it's also not clear what operations can and cannot be in and outside of the United States. There are many folks who use services and vendors who could be a mix of onshore and offshore. I don't think we have clarity right now on that issue. For summary of disclosures, there was a related issue relating to auditable events that we should probably collapse in the summary disclosures. Whose obligation is it to provide a summary of disclosures particularly when these are multisystem and multi-actor queries? I don't think we understand where the obligations rest and for what purposes they rest. If I go query somebody else through a broadcast query via my QHIN, who is obligated to write the summary of disclosures for what? Somebody remind me what CUI stands for.

Multiple Speakers

Controlled unclassified information.

Arien Malec - Change Healthcare - Co-Chair

Oh, got it. Controlled unclassified information. So, I guess the question is - although I'd frame this question - is the TEFCA definition here sufficient to enable federal actors to participate? Because I think many of us have had experience with VHA, with DOD, and with SSA and they all have slightly different information security requirements and slightly different requirements relative to the handling of information. There is the CUI that designation, but it's not clear that that is sufficient for federal actors to participate. Then we talked about certificate authority backup and recovery and whether that is actually appropriate for the MRTCs. Okay. So, David, do you have your hand up?

David McCallie, Jr. - Individual - Public Member

Just on tier 2 on the security tagging, I think there is a much broader question there. I am blanking on what we used to call it. It's a re-disclosure of information. If we require security

tagging, do we create downstream obligations that go far beyond just the creation of the tag? I apologize. I am blanking on the term that we have used in the past for this broad space, but it will come to me in a few minutes.

Arien Malec - Change Healthcare - Co-Chair

Yeah, it's private to sensitive tagging or data tagging. And we had a long discussion about this at the high-tech where I think we noted that the standards were sufficient, but there was no policy enablement. There was no policy enablement for the standards, and we made recommendations for ONC that that was something that needed to be addressed. All right, let's go down to tier 3, and let's make sure all of the tier 3 issues are tier 3 issues. I'd say given the space and pace and time that we have, we may get to tier 3 issues, but we may not. So, if there is something that is really burning that you think should be a tier 2 issue, we should recommend that it be a tier 2 issue. One is ID proofing and authentication. I personally think this should be a tier 2 issue, and shame on me for not flagging that yesterday. Auditable events, I think we addressed that already in summary of disclosures. So, I think we can get to auditable events in the context of summary disclosures.

And organizational identity, it turns out we don't have many tier 3 issues. Our tier 2 issues are basically coextensive with tier 3 issues. So, given that list are there other items that are burning a hole in people's pockets that are not represented as one of our tier 1, tier 2, or tier 3 issues that we would be remiss as a task force for not discussing? All right, hearing none. Why don't we proceed then through the rest of our time together to chunk through our tier 1 issues? When we go back to broad goals, we've already addressed some answer for the broad goals of the TEFCA, and this would be a recommendation to ONC that ONC explicitly state that the TEFCA is there to enable better treatment, better quality of care, and more efficient health system and that we recommend that ONC clearly link participation in the TEFCA to address relevant information blocking requirements for participant actors including H I.T. vendors and provider organizations. So, I think the task force agreed as a group that that was the recommendation.

John Kansky - Indiana Health Information Exchange - Co-Chair

Arien?

Arien Malec - Change Healthcare - Co-Chair

Yeah, go ahead.

John Kansky - Indiana Health Information Exchange - Co-Chair

I know there are opinions out there. I'm trying to agree with you in the sense that I think wordsmithing around that recommendation when it gets crafted that there is hopefully room in there to incorporate sentiment that I have heard. But people feel strongly about this one. I think I agree with you that the general sentiment is captured and that we can wordsmith the recommendation, but I wanted to ask if that was in the interest of time if the task force agrees with that.

Arien Malec - Change Healthcare - Co-Chair

So, John first of all, if there are nuances here that we are not capturing that can be quickly and easily discussed, then we probably should discuss it because I think it's kind of an important one. But then I also agree with you that we will wordsmith the recommendations in the context of recommendations letter. We probably want to go read first before we get to that point.

David McCallie, Jr. - Individual - Public Member

This is David. I would like to hear your nuance, John, just to know what we would be coming back to.

John Kansky - Indiana Health Information Exchange - Co-Chair

So, a couple of things. Arien, I lost track of which task force we discussed this on, but the second bullet about "presume to address some" are the words that I circled because I agree that while on the one hand, my opinion is that I don't think participation in the TEFCA ecosystem should be a complete safe harbor. It should be presumed that anyone in the TEFCA ecosystem obviously is trying to share information and not block information. So, there is a question of what does that mean? If I am participating in TEFCA, what does that assure in terms of not being in trouble for information blocking? That would be point number one. I will get out point number two, and then I will shut up.

Point number two is completely separate. It's the sentiment that TEFCA is supposed to be a framework, and we are using words like obligations. And there are words like conditions of participation that get pulled out in the CMS rule not necessarily linked to TEFCA, but I just want to be clear on it because I know I'm not the only one that has sentiment in this area. I'm trying to speak for a group that I would invite to chime in. Where is the right place on the line between required obligation and voluntary framework for TEFCA to meet its purpose under 21st century cures?

Arien Malec - Change Healthcare - Co-Chair

Right. Okay, those are great points. Sasha has her hand up.

Sasha TerMaat - Epic - Member

Oh, thanks. I think John hit on sort of my nuance here too, which was that when we say link TEFCA participation with info blocking requirements, I can see two directions in which that link might go. Most of our conversation has been around how participation in TEFCA would prove information sharing to some degree or another.

Arien Malec - Change Healthcare - Co-Chair

Yep.

Sasha TerMaat - Epic - Member

And I think if we are also discussing if choosing to not participate in TEFCA in one particular role or another - whichever potential roles might be eligible to a particular actor - implies information blocking, then I think that's a separate conversation we would want to have very explicitly. I share John's concern about the intent of it being a voluntary framework and any

implications from that perspective.

Arien Malec - Change Healthcare - Co-Chair

Yeah, I have not heard from the task force any presumption of participation. In my head, this is more the discussion of a task force around the incentive to participate as opposed to being a requirement to participate. I think the sentiment of the task force is that if I participate in the TEFCA, that should address some of my information blocking obligations and that there are multiple ways to address those same information blocking obligations. So, there is no requirement to participate in TEFCA. I think that is the sentiment of the task force.

Sasha TerMaat - Epic - Member

That's what I've heard also. I just wanted to make sure that as we do that nuance drafting here that that carries forward and I wasn't missing something.

Arien Malec - Change Healthcare - Co-Chair

Yep. David, you have your hand up?

David McCallie, Jr. - Individual - Public Member

Yeah. I think to me it just keeps coming back to the word incentive. The industry is engaged in a ton of activity doing almost everything that TEFCA describes already. So, if it's purely voluntary, why would existing data sharing entities, HINs, become QHIN's? And maybe more to the point, why would participants feel obligated to join a QHIN? There needs to be some incentive that creates an expectation that this is the right thing to do. This is the best way to solve some problem that we are not already solving. And I don't know that we have to enumerate what we think that is, but if ONC expects it to be successful, they better have an idea of why people would go to this.

Sasha TerMaat - Epic - Member

David, I would actually approach from the opposite perspective, which is that if TEFCA is going to be successful it's going to need to have a service that it offers not that we should artificially create one with a regulatory obligation.

David McCallie, Jr. - Individual - Public Member

Well, it could be a variety of pushes and pulls. It just needs to be something that there is an expectation for what it is. It won't happen if you just drop it out there and say let's see what happens. It is too cumbersome. Pushes and pulls, a little bit of both, some reason for people to go disrupt what they are already doing and start over with TEF.

Arien Malec - Change Healthcare - Co-Chair

David, I think the sense of the task force right now is that it's appropriate to have a pull but not a push unless you can frame up and articulate a notion of a push that the full task force would agree with. I think a push has some obligation to participate, and I think the sense of task force is it should be a reason to participate because it gets you something that you don't get by not participating or it addresses obligations that you otherwise have to manually address or address through potentially more cumbersome means if you don't participate.

David McCallie, Jr. - Individual - Public Member

Yeah, I agree. That's why I use the word incentive. That is a pull thought. You have to have a reason that makes sense to you ideally because you want to do it. But if it helps you address other obligations, which might be another regulatory setting like information blocking, that's an incentive.

Arien Malec - Change Healthcare - Co-Chair

Yes.

David McCallie, Jr. - Individual - Public Member

You don't have to create a new push, but we can clearly link it to existing pushes.

Arien Malec - Change Healthcare - Co-Chair

I think at this level we've got the high-level sense of the task force, and I just recommend that we keep going down the list. All right, so applicable law, John, can I pass the baton over to you for leading us through this discussion? Then I can flip over for the QTF discussion.

John Kansky - Indiana Health Information Exchange - Co-Chair

Sure, let me give it a whirl. And I'm going to need help on some of those who were commenting on FTC versus HIPAA. Was that in this category? David, I think that was you.

David McCallie, Jr. - Individual - Public Member

Yeah, that's what I was considering, and I will give you just a test case. We have, some of us, participated in CARIN, a group trying to promote consumer access to their own health data. And CARIN has put out a model code of conduct, which has contextual language that entities who want to access consumer data should hold themselves voluntarily accountable to subject to possibly FTC contract language. It struck me that TEF has some similar kinds of conditions, those minimum necessaries that we talked about yesterday, that kind of overlap and align with something like what CARIN is doing.

So, my question is if I were an entity trying to start a health record bank or some other kind of consumer-driven health service, would I understand why I would want to participate through TEFCA or whether I would just want to treat the APIs as my playfield and bypass the TEFCA because the minimum necessaries are out of sync with what the rest of the industry is doing? So, the things that are regulated under HIPAA we all understand pretty well. It's good to clarify those boundaries. It's this new space of things that aren't regulated under HIPAA where alignment between tasks and other players, is going to have to happen. That is a pretty wordy way of expanding it. Sorry for the wordiness.

Arien Malec - Change Healthcare - Co-Chair

No, that is great. The other area at least that was in my head was in the areas where the TEF includes obligations under HIPAA. Do we have clarity on how and when existing operations already address the TEF obligations, or are creating net new obligations that are extra to HIPAA?

John Kansky - Indiana Health Information Exchange - Co-Chair

Right. That was something I was trying to wrap my head around yesterday. Are there examples that we could offer - I am trying to think of one of myself - that demonstrate the problematic nature of I am a HIPAA-covered entity, and then I go to participate in the TEFCA ecosystem and now it is unclear to me which law applies when?

Arien Malec - Change Healthcare - Co-Chair

It is all of the HIPAA obligations that are placed on QHINs and participant actors that are there in the case where they are not already BAs, or CEs. But is it clear that the BA and CE obligations already address those obligations, or do I have to sort of doubly assure or do different things in different situations?

John Kansky - Indiana Health Information Exchange - Co-Chair

Is this one and the same with or different from the concern that I believe you raised yesterday of when am I operating under the TEFCA and therefore complying with TEFCA-related regulation? And when am I doing things outside TEFCA, and, therefore, do those regulations cease to apply? I don't know if I represented that accurately.

Arien Malec - Change Healthcare - Co-Chair

Yeah, so this is my example. This is really under individual access, and I think we should discuss it at that point. There are activities where I used the example of the food company that has effectively a health record bank that's maintained on device, and actors may be enabling individual access to store the data and then subsequently enabling data dispersal of data for research purposes. And, again, not to be coy, but this is exactly the model that the arrhythmia study that Apple and I forget who else, Stanford, participated in. That was exactly the model that they used was the watch, the Apple watch, stored data in the health app, but also any data that I pulled down from participating health systems also gets stored in the health app.

And then as a consumer, as an individual, I authorized Apple to share that data for research purposes. I think there is a resumption in the TEF that those would be TEF activities, and I think there is a presumption that other people would have that those would be on the individual access or sort of the individual determination of where their data goes side. I think we need to be clear about that, but I would put that under the individual access space.

David McCallie, Jr. - Individual - Public Member

This is David. I agree. Most of the things I was thinking of are centered around individual access because that is where we bring in a new regulatory framework with contractual commitments under FTC. And my concern is the NPRM is creating clear mandates for direct consumer access via APIs to their own data. The TEF creates an alternate channel for that data access that has theoretical advantages in that you could get all of it all at once.

Arien Malec - Change Healthcare - Co-Chair

Yes.

David McCallie, Jr. - Individual - Public Member

We need to be clear that there is not something that stops that from being operational because people don't like the constraints or the constraints don't fit existing laws, etcetera. So, how does that lineup with the API requirements under the NPRM? We will get at this, I think.

John Kansky - Indiana Health Information Exchange - Co-Chair

And do you see that as something we will get to under IAS then?

David McCallie, Jr. - Individual - Public Member

I think that is a question to Arien.

Arien Malec - Change Healthcare - Co-Chair

Well, the issue that you are raising, is it appropriate to discuss under the IAS distinction as opposed to the applicable law distinction or discussion point?

David McCallie, Jr. - Individual - Public Member

Sure. Although, I think the sticking point may be some of these MRTCs, the minimum necessary in particular, and some of the things about reciprocity constraints if you are an IAS actor. So, yeah, most of them are IAS related-questions. I agree.

John Kansky - Indiana Health Information Exchange - Co-Chair

Let's make sure that we are touching on other things that we have captured in this box, and I want to make sure I am tracking. So, others, please help me. Differences in roles for covered entities and BAs as it relates to provisions in the MRTCs, can anyone elaborate on or champion that one?

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead

I can give you as an example of one that you might want to look at, the breach notification requirement 6.1.1. That has specifically the requirements that are applicable to business associates. And then there is an additional if the QHIN is a covered entity. It has additional responsibilities. So, I think that was brought up yesterday. Like, when does the TEFCA entity that has to comply with the provision, when do they have to satisfy the role as the covered entity, or are they satisfying the role as a business associate if that is different?

Arien Malec - Change Healthcare - Co-Chair

Right. There are also notification requirements. There are accounting for disclosures requirements. There are additional requirements that overlap with existing requirements already under HIPAA that may be also obligations of a BAA that are delegated.

David McCallie, Jr. - Individual - Public Member

Go ahead, John.

John Kansky - Indiana Health Information Exchange - Co-Chair
No. Go ahead, David.

David McCallie, Jr. - Individual - Public Member
I say this is another thing that maybe that comes up under IAS, but you don't need a BAA to access the APIs as a consumer aggregator. Do we by creating new requirements under TEFCA drive those users, those IAS potential users, away from TEF because of asymmetrical requirements - inspector and regulatory? That's a question.

John Kansky - Indiana Health Information Exchange - Co-Chair
Back to the point the example that Zoe gave and making sure we are clear on that point, my understanding yesterday is that the requirements in here that are, I'll call it, a subset of HIPAA are specifically applying to non-covered entities. And so if you are a covered entity, HIPAA rules apply and should be unambiguous to you. If you are not otherwise covered by HIPAA, these are your requirements. Is there ambiguity in there that we need to weigh in on?

Arien Malec - Change Healthcare - Co-Chair
Is that clear? And, again, probably shame on me. I read that TEF back to front.

John Kansky - Indiana Health Information Exchange - Co-Chair
You should have read it front to back.

Arien Malec - Change Healthcare - Co-Chair
I should have read it front to back. Is that clear, Zoe, that the obligations under the TEF that already covered entity and BA obligations apply only in the case where the HIN is transacting on behalf of a non-covered identity and doesn't have a BA? Or do they apply independently of whether I have a BA or I'm a covered entity?

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead
I may have gotten lost in a double negative in there, but I think what you are saying is they apply. The provisions and MRTCs apply to everyone regardless.

Arien Malec - Change Healthcare - Co-Chair
That's what I thought. That's what I thought. Yeah.

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead
Yes.

Arien Malec - Change Healthcare - Co-Chair
So, the provisions apply whether I'm a covered entity or a BA as a covered entity, which is why I am raising this question of they apply because I might not be a BA or might not be a

covered entity. We want to make sure the applicable parts of HIPAA apply to those actors. But I'm already a covered entity and already a BA. Do I now have slightly different overlapping sets of obligations that I need to approve compliance to?

John Kansky - Indiana Health Information Exchange - Co-Chair
It sounds like the answer may be yes.

Arien Malec - Change Healthcare - Co-Chair
Yeah.

John Kansky - Indiana Health Information Exchange - Co-Chair
Perhaps that doesn't sound particularly elegant to me. Are there makings of a recommendation there?

Arien Malec - Change Healthcare - Co-Chair
I would propose a recommendation that covered entities and BAs for covered entities should - or I want to create the effect of a safe harbor, basically - that are already meeting the appropriate obligations are meeting those appropriate obligations and don't need to or should not need to address additional contracting terms unless there are particular requirements that are extra to HIPAA and BAA terms. And maybe recommendation number two is that ONC should be utterly clear in the MRTCs which of the obligations would normally be addressed through BAAs or the covered entities' existing obligations and which of the obligations are extra to those obligations.

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead
Arien, to make sure I'm following you, can I throw an example out there and see if this is what you are talking about? So, like the written privacy summary, for example, I guess based on kind of what I heard from you is that if you are a covered entity or business associate and you are already doing the notice of privacy practice through HIPAA, then you shouldn't additionally have to do a second written privacy summary just for the purposes of the TEFCA.

Arien Malec - Change Healthcare - Co-Chair
Right. And if I'm a HIN who contracts with covered entities and does not contract with non-covered entities, I shouldn't need to force my covered entities to already submit a notice of privacy practices because they are already doing that.

John Kansky - Indiana Health Information Exchange - Co-Chair
And, again, we will craft this in a recommendation and review it, but I think I heard that there were two suggestions we might give the ONC. One is option A, participation in HIPAA should be a safe harbor if it's close enough to avoid this two-regulations problem, or, alternatively, if you are going to say, yeah, the notice of privacy practices is good enough, you just need to add these specific two things to be super extra clear on what those two things are. Yeah.

Arien Malec - Change Healthcare - Co-Chair

Totally.

John Kansky - Indiana Health Information Exchange - Co-Chair

Okay. I was interested in disruption to current arrangements, and somebody offered a good illustrative example, which I have now lost, earlier in the call. Does anyone remember? Zoe, it may have been you. I don't want to put you on the spot. Go ahead. Thank you.

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead

I think it ties into sort of everything that we have been talking about in the past few minutes. I's the idea that we have this new regulatory landscape and we don't want to be adding additional disruptions to already existing agreements and existing BAA's.

John Kansky - Indiana Health Information Exchange - Co-Chair

I think I got it. Now that I think about it, it probably is an accurate presumption. I think it's actually stated that there is a presumption that TEFCA would require - let's pick on participants and participant members because I think they are a clearer example - if you already have an agreement, there is a presumption that your agreements are going to have to be modified if you're going to participate in the TEFCA ecosystem. I was taking that as kind of an inconvenient truth of TEFCA. Is that not where everybody else is?

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead

That is the intent that, yes, the agreements would have to be modified.

John Kansky - Indiana Health Information Exchange - Co-Chair

Taking off my chair's hat and putting on my health information exchange guy hat, that is one of, if not the scariest thing about TEFCA.

Arien Malec - Change Healthcare - Co-Chair

Yes.

David McCallie, Jr. - Individual - Public Member

That's why I'm concerned about incentives.

Arien Malec - Change Healthcare - Co-Chair

Yes. And in the CommonWell example, we had rooms of lawyers working out the participant agreements. I know that in the care quality example working out participant agreements required additional rooms of lawyers. So, we've already burned our lawyer quota, and it would be highly inconvenient to re-burn the lawyer quota.

David McCallie, Jr. - Individual - Public Member

And on top of that, just to make it worse, rolling out a change to a client base, it re-invokes legal review with every word you change in these documents, and that can take literally

years to roll out across a large client base.

John Kansky - Indiana Health Information Exchange - Co-Chair
I don't want to presume the point of view of the entire task force, but, Zoe, other than ONC hearing that that is a really scary part of TEFCA, what else would you like us to discuss?

Arien Malec - Change Healthcare - Co-Chair
And, again, I think it would be a flaw of the TEFCA if existing networks that have operated in good faith and actually established mutual internetwork operations in practice would then be obligated to go back and reword contracts and go through this laborious process yet again. So, this is where being ultra explicit around here are the new things and also creating maybe safe lanes or appropriate paths where if I have language, I don't have to have the explicit language. I should be able to map language that I already have to the obligations under the TEF.

John Kansky - Indiana Health Information Exchange - Co-Chair
Arien, maybe that's what you are trying to say, but rather than just feeding back to ONC, yeah, if you make us rewrite our agreement, that's a huge problem, is there is any way to not have us to have to redo all of our agreements and not destroy TEF?

Arien Malec - Change Healthcare - Co-Chair
Right. And, again, the point here is can we make things rather than written legal agreements? The way the MRTCs work is they are effectively written legal language that ONC's lawyers, who are fantastic, have drafted which would then be presumed to have to slow down into RC obligations, QHIN obligations, and participant obligations, which would require redrafting contacts and reopening this massive can of worms. Is their approach instead where existing networks and participants can look at their language that is functionally equivalent to the model? Can we think about this as a model language exercise as opposed to an actual legal contract that is the actual literal MRTC terms?

John Kansky - Indiana Health Information Exchange - Co-Chair
Yeah. Or even a process maybe where I give a network and say hey, can you guys look at my agreement and tell me if it meets the intent and is therefore okay? Because that would save me. Okay, that was helpful.

Arien Malec - Change Healthcare - Co-Chair
That was knee deep.

John Kansky - Indiana Health Information Exchange - Co-Chair
Yeah.

David McCallie, Jr. - Individual - Public Member
This is David, just a thought on that. I wonder if there is a subset of the core purposes for which existing networks are actually already under operation where you might be able to

sort of grandfather them in quickly and have it sort of non-disruptive, no-new contracts for those core operations? But for some of the newer permitted purposes, maybe like individual access or something like that, you recognize that those require extensions to contracts so that you kind of split the world between stuff that's already working pretty well versus the stuff that's new enough to justify the actual legal review.

John Kansky - Indiana Health Information Exchange - Co-Chair
Okay, is there anything else? Go ahead.

Mark Savage - UCSF Center for Digital Health Innovation - Public Member
This is Mark Savage. I am sorry. I was off the phone, so I missed most of the conversation. But from your experience, does it help to instead of thinking of changing an existing contract to think of adding a new contract that's just focused on TEFCA? Does that help at all?

Arien Malec - Change Healthcare - Co-Chair
If there are clear amendments, this is why we recommend. This is why we want to recommend that if there are genuinely new obligations that they be explicitly marked as genuinely new obligations and, secondly, that there be a process to map existing contractual terms to the model MRTC terms. But, in general, it is easier to say, hey, here is an amendment that you are signing because you are participating in the TEF, and that's a good thing for you because of all of these benefits that you get as opposed to opening up a contract that exists. So, I'm sort of rambling but to the extent this can be framed as genuinely new terms where you get to address all of the existing terms through your existing contract and only do an amendment for the changes, that's logistically easier - although it's still hard - than opening up all of the legal language that you've already negotiated and already gotten people to sign that is identical to in spirit but not in letter the MRTCs.

John Kansky - Indiana Health Information Exchange - Co-Chair
Yeah. So, I will just echo. I think where my opinion is trying to form is the compromise position may be there is no way that ONC can get what it believes TEFCA needs to be without forcing the rewrite or amendment of some agreements. But it would be great if there were two things: A, a little bit of hey that's close enough, so you don't need to fix that; but, B, some way to get to, okay, here are the things that you really have to rewrite in your contract. So, this is the least threatening as possible amendment that you need to go back to your participants with. Not at all sure how to accomplish that, but that sounds like good work for RCE. Are we okay to move on? Go ahead.

Arien Malec - Change Healthcare - Co-Chair
Before we move on, that's right. Before we move on, I just want to make sure the people on the phone who are phone only have their say. We haven't really been raising our hands, but that's okay.

Anil K. Jain - IBM Watson Health - Member
Yeah, this is Anil. I am good. I'm listening and absorbing, and, again, I might have more to say later when I review everything. But I like the dialogue and the controversy around some of

the nuances that were pointed out by John and others. Thanks.

Kathryn Marchesini - Office of the National Coordinator for Health Information Technology - Chief Privacy Officer

This is Kathryn. I just had a question for clarification. So, in your recommendations, what would happen if an organization or entity, for example, is not covered by HIPAA or there is not an existing agreement in place? With this being a common agreement, is there a recommendation to still have something about which an organization would agree to that would be rooted in the MRTCs so there would be an agreement? I'm just trying to think through that.

Arien Malec - Change Healthcare - Co-Chair

I don't think any. I shouldn't say that. I'm going to poll the sense of the task force, but I would presume that the task force thinks that it's a reasonable thing understanding that non-covered entities are not bound by HIPAA to establish at least a minimum floor. The discussion that I've heard has been more around areas where you've got existing networks who are primarily networks of covered entities and where the agreements that have been negotiated with appropriate BAA terms, etcetera, already address many of the MRTC terms that we not go back and rewrite those. I believe there is - and maybe just frame up for the task force, any violent disagreement - a consensus that in areas where those terms don't exist or where those obligations don't exist on those actors that it's appropriate to make sure that those obligations be clearly placed through contractual terms on the actors.

John Kansky - Indiana Health Information Exchange - Co-Chair

I will add. So, yes, there is absolutely no - John Kansky's opinion - pushback against the idea that where there needs to be an agreement, there should be an agreement. What you are hearing I believe, Kathryn, is that - using my organization as an example - it's taken us 15 years to build our network around a common agreement using those words deliberately, one organization at a time. And the idea of going back to organizations, it is not a small deal to go back to them and say that thing that you are comfortable with but maybe just barely, I have to ask you to completely reopen that, relook at it, and decide if you want to sign again. It is frightening.

Kathryn Marchesini - Office of the National Coordinator for Health Information Technology - Chief Privacy Officer

Yes. That is helpful. Thank you all for that. Part of it I think, and Zoe can probably attest to some of this, it's trying to meet, I would say, the statutory requirement that this is a common agreement. So, I look forward to bringing kind of what the group recommends and trying to square that with the mapping to existing agreements. So, helpful. Thank you for that.

Arien Malec - Change Healthcare - Co-Chair

Cool. Thank you.

John Kansky - Indiana Health Information Exchange - Co-Chair

Thank you.

Arien Malec - Change Healthcare - Co-Chair
All right, should we go to exchange modalities in the QTF?

David McCallie, Jr. - Individual - Public Member
Oh, joy.

Arien Malec - Change Healthcare - Co-Chair
Yeah. So, I'm going to frame up an exchange modality question before we go into the QTF. And maybe I'm going to frame two exchanged modality questions. One is in the exchange modalities themselves, do we understand what is meant by broadcast query? And do we believe that the broadcast query is sufficient to meet the needs of the TEF? And then with respect to directed exchange, do we understand what is meant by directed exchange, and do we believe, again, the functional requirements or MRTC requirements relative to directed exchange are sufficient to meet the policy goals that we have articulated? And this is independent of whether we think the QTF is appropriate. This is more do we know what we are actually shooting for that we should be judging the QTF against?

David McCallie, Jr. - Individual - Public Member
Arien.

Arien Malec - Change Healthcare - Co-Chair
I'm going to presume David raised his hand.

David McCallie, Jr. - Individual - Public Member
Yeah. I was going to say you need to be careful with that phrase directed exchange. I think message delivery.

Arien Malec - Change Healthcare - Co-Chair
Message delivery, that's fine. Push delivery, whatever.

John Kansky - Indiana Health Information Exchange - Co-Chair
Just to use ONC's vernacular, our choices are targeted query, broadcast query, and QHIN message delivery.

Arien Malec - Change Healthcare - Co-Chair
QHIN message delivery. I think I understand what targeted query is. I do not understand in the definition of the TEFCA 2 what broadcast query is, and I am not sure I understand what message delivery is. So, I think the purpose of message delivery is primarily around public health and delivery of, for example, surveillance reportable conditions, reportable labs, for the surveillance to state actors. Do we understand the message delivery functional requirements to be sufficient for those purposes? Let me just frame up those two questions. Number one is do we understand what broadcast query is in the MRTCs and exchange modalities? And do we believe that the broadcast query is sufficient to meet the policy goals

that we have articulated and established?

John Kansky - Indiana Health Information Exchange - Co-Chair

Arien, I will be the Laurel to your Hardy on this one. That was a really old reference. So, a broadcast query is when a participant member sends something labeled a broadcast query up to their participant who sends it to their QHIN who says, yeah, this is a query that needs to go to everybody. Please send it out, and let's bring all the responses back together. So, I understand conceptually I think that's what we mean, but then when you start to play out, wait a minute. That doesn't work. That's really your point. Logically, we cannot wrap our heads around how that would work without a ROS. Or how long do you wait for responses and how long to get aggregated? Is that where you are going?

Arien Malec - Change Healthcare - Co-Chair

Yeah. So, the TEF 1 establishes a functional requirement for an ROS. The TEF 2 definition of QHIN broadcast query is a QHIN's electronic request for EHI in the context of the common agreement; the request EHI from all other QHIN's to the extent permitted by the common agreement and applicable law. So, first of all, I'm a QHIN. I'm obligated to send it to every other QHIN. And then I'm a QHIN who's received a broadcast query. What do I do with it?

John Kansky - Indiana Health Information Exchange - Co-Chair

You broadcast it to everybody who broadcasts it to everybody else.

Arien Malec - Change Healthcare - Co-Chair

That sounds like a bad idea.

John Kansky - Indiana Health Information Exchange - Co-Chair

It does.

David McCallie, Jr. - Individual - Public Member

And we watch the lights go dim. This is David, I think part of the problem is the broadcast query presumes a technical approach by the word broadcast, and it really ought to be cast as a functional requirement. I would say use federated query and the definition of what federated query should accomplish, and then let the RCE figure out how to make it stale. Right?

Arien Malec - Change Healthcare - Co-Chair

That is exactly the proposal that I have in my head. If you actually read the TEF 2 and you read the definition of broadcast query as a capitalized and bolded term in the MRTCs, the definition of a broadcast query is a QHIN electronic request for an individual EHI in the context of the common agreement that requests EHI from all over QHIN's to the extent permitted by the common agreement or applicable law. So, the functional obligations of a QHIN is to query other QHINs. I think there is a functional obligation to respond, but I'm not sure what to do with the response. I get wrapped up on this because I don't understand what the response obligations of the QHIN's are.

David McCallie, Jr. - Individual - Public Member

Arien, are you confused about their language? Or are you confused about what you think ought to happen?

Arien Malec - Change Healthcare - Co-Chair

I am confused both about what is supposed to happen in the proposed language, and I suspect that it's not what should happen. So, again, the definition of a targeted query is that a QHIN asks a QHIN for information. But, again, I don't understand functionally. Let's even take the notion of a targeted query. Do we understand if you were designing and operating a QHIN - so, John Kansky with IHIE - and you received a targeted query, do you understand what you should do with a targeted query? Because in the context of the TEF 2 a targeted query is not a query of a provider or a hospital or location of care. It is a query to another QHIN for information about EHI.

John Kansky - Indiana Health Information Exchange - Co-Chair

My assumption on a targeted query was that, A - and I'm going to go all the way down to participant member on purpose - a participant member needs to get some information that resides in another participant member who participates in a completely different QHIN. But the transaction identifies that participant member and its QHIN. So, it sends it up through its QHIN, over to the other one, down to that participant member and brings back the answer. That to me is what I was thinking.

Arien Malec - Change Healthcare - Co-Chair

That's not the way it reads.

Sasha TerMaat - Epic - Member

Would it be helpful to look at figure 1 because I think you are trying to illustrate this? And I worried it oversimplified what would actually happen.

Arien Malec - Change Healthcare - Co-Chair

Yeah. We can look at figure 1, Sasha. I am just reading the language though. So, I am reading the actual language in the MRTCs.

Sasha TerMaat - Epic - Member

That's fair.

Arien Malec - Change Healthcare - Co-Chair

And the definition of a targeted query is a QHIN electronic request for an individual BHI, sometimes referred to as a pull, from specific QHIN's. In the context of the common agreement, it's the extent permitted by the common agreement and applicable law. So, the only reason for using targeted query and broadcast query is whether one QHIN asks a defined set of another QHIN, or whether one QHIN asks literally all QHINs for information about EHI. There is no obligation in the definition of a targeted query that it be for a setting of care. Sorry, figure 1. Sasha, can you tell me which page figure 1 is on?

David McCallie, Jr. - Individual - Public Member
It's 81, page 81.

Male Speaker
It might also be helpful to review section 2.2.1.

Arien Malec - Change Healthcare - Co-Chair
I don't know what I'm looking at on 81.

Male Speaker
I have on page 80 of the QHIN technical framework draft.

Sasha TerMaat - Epic - Member
Arien, I don’t know that it matches what you've described in the language.

Arien Malec - Change Healthcare - Co-Chair
It doesn't match the definition.

Sasha TerMaat - Epic - Member
Yeah.

Arien Malec - Change Healthcare - Co-Chair
No. It doesn't match the definition in the language.

Sasha TerMaat - Epic - Member
Yeah. I am also concerned that this diagram is misleading, or I guess oversimplified at least.

John Kansky - Indiana Health Information Exchange - Co-Chair
Can you elaborate?

Sasha TerMaat - Epic - Member
It doesn't seem in our review to match the that are standards specified for actually performing this, or it is over-prescriptive about how those would be implemented.

David McCallie, Jr. - Individual - Public Member
It leaves out a lot of steps.

Arien Malec - Change Healthcare - Co-Chair
The reality is everyone who has done this has done some form of an RLS to address the multitasked problem. And some form of a ROS can mean geofencing and geolocating a query can refer to individual participant preferences regarding high-priority settings of care, can include a literal RLS that is a demographic link across locations of care or can include, in some cases, a full document repository where the actor is not only providing the RLS but also the

response. And each of those exchange approaches has been used in practice and has demonstrated value in practice. And this approach, the definitional approach, seems to be none of them, and the proposed sequence diagram appears to be maybe one of them. Although it's, again, not really clear how it would work in the context of the broadcast query.

John Kansky - Indiana Health Information Exchange - Co-Chair

So, how do we provide useful feedback to the ONC? It sounds like there is some lack of clarity on what is intended by the modalities. There may be some proceeded contradiction between language and diagrams. There may be some lack of detail or perhaps too much specificity. I don't know where to go.

Arien Malec - Change Healthcare - Co-Chair

Yeah. Go ahead, David.

David McCallie, Jr. - Individual - Public Member

Well, I think the best way to deal with this, given that there will be an RCE that has stakeholders with a deep understanding of the technical choices, is the clearest possible functional requirements for what you expect these things to do but to stay away from any description of how they should do them. Let the RCE figure that out with the stakeholders.

Arien Malec - Change Healthcare - Co-Chair

I completely agree with that. And I also think that we have a natural understanding of what a targeted query is and a broadcast query is. We probably should propose that the natural understanding should be reflected in the TEF terms. I think we would all think a targeted query is a specific request to a specific location of care. It is mediated through one or more QHINs. And I think we would expect that a broadcast query is a request for patient information regardless of the location of care where the QHIN or where the responding QHIN takes appropriate measures to make sure that the appropriate data is returned but where we don't specify the mechanism for how all of that stuff happens and allow for modalities where we run RLS, modalities where we run document repository, modalities where we apply appropriate heuristics to retrieve data.

I guess that would be the proposal that I would have, that we define functional requirements for what a broadcast query is and a targeted query is and then remove the QTF implementations and punt it to the RCE and the QHINs to work out what actually would mean in practice.

John Kansky - Indiana Health Information Exchange - Co-Chair

That all made sense to me. Go ahead.

David McCallie, Jr. - Individual - Public Member

I was going to say that made sense to me too. I would consider possibly adding the notion that we might want at a functional level to suggest something about what kind of stuff you expect to get back on these queries. Again, in the real world, the existing entities have already settled on some fairly consistent standards but sort of saying things like you expect

to get a summary of the current best knowledge of that patient plus a list of encounters available for deeper information is needed. Something like that at the high-level would probably be okay to put at the functional level without actually diving into saying XCA or CVA version 2.1, modified, blah, blah, blah.

Arien Malec - Change Healthcare - Co-Chair

We are being gently reminded to go to public comment. Mark has his hand up. Let's go to Mark first and then go to public comment if that's okay?

Mark Savage - UCSF Center for Digital Health Innovation - Public Member

Thanks. Thanks, Arien. This had been implicit in people's comment, but I'd just like to make it explicit. I think it would be good to hear from ONC how they think this works, what they might want, how they might explain the difference between the language and figure 1 before we do the work that's just been outlined. I just am curious to hear. They have heard us. We haven't really heard from them. I'm curious to hear.

Arien Malec - Change Healthcare - Co-Chair

Okay, that's a good point. So, maybe for the next call we can line up a presentation from ONC about what they intended for targeted query and broadcast query?

Mark Savage - UCSF Center for Digital Health Innovation - Public Member

Agreed.

Arien Malec - Change Healthcare - Co-Chair

Okay. Should we go to public comment?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Sure. Operator, can you open the line?

Operator

If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate you are in the queue, and you may press *2 if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the * keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Do we have any colors in the queue?

Operator

We have none at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology -

Designated Federal Officer
Okay, thank you. Arien?

Arien Malec - Change Healthcare - Co-Chair
Okay. So, there is some good public comment or chat between Sasha and David on the worry that the way broadcast query is defined is that it could well be a brute force - quote, spray and pray, unquote - and I think everyone on this task force would acknowledge that that is architecturally unsound.

David McCallie, Jr. - Individual - Public Member
Arien?

Arien Malec - Change Healthcare - Co-Chair
Yeah.

David McCallie, Jr. - Individual - Public Member
One other thing to think about in this context is in the NPRM there is some language about an ADT notification to presumably a community of providers that should know about a patient encounter or patient activity. In discussions with Doctor Rucker at HIMSS, the CommonWell team raised the possibility that the ADT notification could become the basis for building a national record locator capability. And he specifically said please put that in your recommendations to us. He thought that was a good idea. So, I would just say this is another place where there might be a link back to the information blocking rule that says it is not only okay for you to use your ADT activity for this purpose. You should use your ADT activity for this purpose of building the record locator.

Arien Malec - Change Healthcare - Co-Chair
Okay.

David McCallie, Jr. - Individual - Public Member
This is a place where TEFCA could clarify.

Arien Malec - Change Healthcare - Co-Chair
Yeah, we could do it as a task force discussion. That seems like it's a specific CommonWell discussion, and I'm trying to separate that in my brain as a task force chair.

David McCallie, Jr. - Individual - Public Member
Yeah. I was just saying that was the context of the conversation, but Rucker's request was broad as a part of a generic record locator capability. As you know there's a lot of concern of I shouldn't use ADT data for this purpose, or I cannot use this data for this purpose. Or I don't want to use ADT data for this purpose, but I think TEFCA's success depends in large measure on convincing people that, in fact, they should and can use ADT data for this purpose.

Arien Malec - Change Healthcare - Co-Chair

Okay. So, this is around the question of when is it appropriate? This is the discussion that CommonWell was involved in and care quality that ended up being a fairly thorny issue around establishing norms that it's appropriate to use the output of query activities or the output of message delivery activities to inform future query activities to optimize the results of those queries. I'm trying to put this in very neutral terms. I know that if data was found in location B, it should be appropriate subsequently to use that knowledge to make sure I am querying location B because I have updated my priors.

David McCallie, Jr. - Individual - Public Member

Correct. And even more direct or more clear, patient ADT activity, which is mentioned in the NPRM as something that should be used to distribute messages to providers, it should also be available to update a record locator. So, you get a direct awareness of where the activity occurred.

Arien Malec - Change Healthcare - Co-Chair

I'm trying to use the language of the TEF and talk about message delivery, targeted query and broadcast query because ADT notification is not an exchange modality in the TEF. Okay. We have two more minutes. Anybody else want to get a word in before we adjourn? I think when we come back we will explore this topic in more depth. I think we've got some decent first pass recommendations, and we also said that our the next meeting, which I think is on Tuesday, we will ask ONC to update their perspective or their understanding of the definitions of the targeted query, broadcast query, message delivery, and what was intended. Sheryl?

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Yes, I am sorry. I wasn't able to get my hand raised before, but I did just want to say that the way I read the TEF, which I know we have a lot of technical people on here, I don't know if we want to have all of these technical solutions because at the end of the day there may not be the ideal solution to deliver something today. But that doesn't mean it shouldn't be a goal, and maybe it's more the implementation process and schedule that is impacted versus that it's actually included as a goal of the environment. Because I do still believe that public health should be part of this even though there is not a good solution for providing those public health reports today. There will be if we stay a direction, and that is what I thought they tried to do was strip out the technical aspect and make this a business function of what is supposed to be supplied. So, that it allows for it to grow and innovate and go forward.

Arien Malec - Change Healthcare - Co-Chair

Thank you, Sheryl. I think the task force generally agrees because it's what we said last time, which is that the TEF should outline functional requirements that are sufficient to meet the policy goals. We have yet to look at message delivery and the functional requirements that are outlined there. I think in the discussion so far we have looked at the functional requirements for targeted query and broadcast query and concluded that those functional requirements are insufficient for the policy goals. But we are over time, and we will meet again on Tuesday I believe.

Multiple Speakers

Thank you.

Male Speaker
Talk soon. Bye.