Trusted Exchange Framework and Common Agreement Task Force

Transcript
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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

Operator

Thank you. All lines are now bridged.

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

Good afternoon, everyone. And welcome to the TEFCA task force meeting. Today, we will continue reviewing the recommendations that are going to be presented next week at the HITAC. I'll start with role call first so we could get going. Your co-chairs, John Kansky and Arien Malec, are here. Is Carolyn Petersen here?

Carolyn Petersen - Individual – Member

Yes, I'm here.

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

Great. Aaron Miri. Sheryl Turney. Sasha TerMaat. Steve Ready. Cynthia Fisher. Anil Jain. Andrew Trustcott. Denise Webb.

Denise Webb - Individual - Member

I'm here.

Cynthia Fisher - WaterRev, LLC - Member

Cynthia Fisher is here.

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

Oh, okay, great. Thank you, Cynthia. 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 afternoon.

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

Noam Arzt.

Noam Arzt - HLN Consulting, LLC - Public Member

I’m here.

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

Grace Terrell - Envision Genomics - Public Member
Here.

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

Arien Malec - Change Healthcare - Co-Chair
All right. So, we as mentioned are lining up for final recommendations to the advisory committee next week, which means that whether we like it or not, what we do today has got to be final or pretty close to final. We’ll send out a draft update and get feedback via email. I don’t think we’ve got another meeting on the books. Maybe I’m wrong.

John Kansky - Indiana Health Information Exchange - Co-Chair
We have one more next week and –

Arien Malec - Change Healthcare - Co-Chair
One more next week.

[Crosstalk]

John Kansky - Indiana Health Information Exchange - Co-Chair
We can use that to vote on majority/minority stuff if we need to.

Arien Malec - Change Healthcare - Co-Chair
Yeah. Sorry, we’ve got one more on Tuesday but that really should be final last weeks. And what I’d like to do is get through the whole document today. We had some early fireworks but we’ve gone through all of these issues over and over again. So, what we’re trying to do is either probe for a consensus opinion that can attract a significant majority. We’re not looking for – like we did last time, for a group this small, we’re not going to count five to three as majority clear. But if we can get most of the task force with a few dissenters then, we’ll present that as the consensus opinion and make it clear that there is a strongly held minority opinion. So, we’ll try to get to that. And fortunately, this session as I said is early fireworks because it’s got all of the contentious issues in it.

Really, the middle of the document is where we have all of the fun issues. And then, the heads and tails of the document should be easier to walk through. So, first of all, any questions on the process that we’re going to be using? I’m going to be pretty deliberate

about walking through this and, John and Zoe if you can watch my back so we don't get down too far into issues. I just feel like we've discussed these things over and over again and our risk is people getting ossified in their positions as opposed to final clarity that we get in the last moments.

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

Arien, it's Mark. I'm off the grid next week. So, if anything is passed out this week, I can look at it this week before leaving Saturday.

Arien Malec - Change Healthcare - Co-Chair

Okay. I appreciate that. Enjoy being off the grid. That is a fantastic – I love being places where I literally have no cell signal. All right. So, our first fun issue is regarding the notion of a single on ramp versus the notion of specialty QHINs. And I think, at this point, we're going to go to – I was asked to produce a diagram. I did produce a diagram. I think many people thought it was confusing. But nonetheless, I'm going to walk through the diagram that I produced. And I actually think one thing that became clear in this so I did, basically, the ugliest of all Power Point diagrams with sort of dumb pseudo UML lollipops for interfaces and that kind of thing. So, deliberately ugly diagrams. But what you see on the right is a participant, in this case, an EHR, that is contracting with "a full QHIN".

It does all modalities and exchange purposes. And on the right is our example and we can replace our example with other kinds of examples of a HIN that, in this case, is a public health aggregator, particularly for reportable conditions, lab, reportable labs, and the like so surveillance activities.

Noam Arzt - HLN Consulting, LLC - Public Member

Do you mean on the left? You just said on the right side.

Arien Malec - Change Healthcare - Co-Chair

Thank you. I have systematic left/right confusion issues. So, yeah, thank you. So, on the left of the HIN is the specialty HIN that addresses the use cases. And the question is what has to happen in the middle. So, on Slide 2, we are positing that there is some sort of allowance for a special purpose QHIN that can morph to the needs of its particular participant and participant members. By the way, there's a key aha here that we had both through this diagram and in subsequent dialogue that I'll surface in just a bit. So, here, we have a special purpose QHIN that effectively morphs to the needs of its participant and participant members. And it is able to adopt the MRTCs and the QTF specs that are relevant for that particular use case or usage scenario.

And in this case, it adopts message deliver. It adopts any general MRTCs as well as MRTCs that are specific to public health reporting. And it serves as a single QHIN drop point for all of the state based surveillance systems that it puts a façade over. Slide 3 presents an alterative view of the world and this is a world where everybody has to contract with a full service all QHIN. And the aggregator contracts with the full QHIN accepts all flow down terms. And the question is whether it's all flow down terms or all relevant flow down terms. And it's, basically, contracting for a set of capabilities that it doesn't need. And it's putting an extra

hop and presumably some extra cost in the middle.

And one of the key things that came out of the subsequent discussion is that if you look on the right, I'm not looking at this through a mirror, an EHR with a HIN interface, I think there's a presumption that all participants and participant members serve all exchange modalities and exchange purposes. And that's written into the TEFCA with one exception for individual access with an allowance that an individual access member may only respond to individual access queries. And then, in the subsequent discussion, we've invented another special purpose participant, which is why I chose the public health surveillance use case. And then, if we did a little deeper, we might find other special purpose participants. So, for example, SSA for disability determination makes sense for SSA to be a querier for and receiver of data.

I'm not clear it makes sense for SSA to respond for all exchange modalities and all exchange purposes. So, if you query SSA for hey, do you know anything about this patient, I'm pretty sure that SSA is going to say no, I don't have – and you can solve that in one of two ways. You can say yeah, SSA doesn't have rights to do it. It doesn't make sense so they're just going to say no. Now, SSA is in the beautiful position of never having to worry about being an information blocker. But the other way to think about it is to say look, there's a range of usage scenarios that make sense for some exchange participants, some participants and participant members. And some participants and participant members have the full range of exchange modalities and the full range of exchange purposes. So, an EHR provider needs to do public health reporting. They need to query.

They need to be queried. They need to be queried for a wide variety of purposes. It makes sense for those providers to contract with a full service QHIN that addresses all of the exchange modalities and all of the exchange purposes. And then, maybe there are some limited purpose participants and participant members. And then, the question is if you buy that perspective, are there QHINs that can morph to just the needs that those participants and participant members need and want to support? So, that's the diagram. It either caused sartory in all members or it caused incredible confusion or maybe some mix of the two. I see a couple of hands up. I don't know whether John's hand went up first or Noam's hand went up first. But let's go to Noam, John, Denise, and David in that order.

Noam Arzt - HLN Consulting, LLC - Public Member

Okay. Just some initial reactions. First, in your SSA example, I'm not sure it's unreasonable for a citizen claimant to be able to query SSA and say tell me about my claim or tell me about the clinical data that was sent to support my claim because that's usually where the disagreements come in, right, is what the clinical community is representing about a patient that might then cause a claim to get denied. So, I'm not so quick, if I understood you correctly, to let SSA off the sort of query book because, in fact, the use case says I might want to know a lot about what SSA has now been told about me by someone clinical.

Arien Malec - Change Healthcare - Co-Chair

Noam, that is a fantastic point. I still would assert that if a provider organization queried SSA for quality improvement activity to adjudicate clinical quality measures for MIBS that SSA probably shouldn't return the individual's data for that purpose. And, again, you could treat

that as that's allowed because they don't have rights and that's not applicable law. Or you could treat that as saying SSA is going to sign up for IAS and as a query receiver of data for this particular use case but these other use cases aren't relevant to them.

Noam Arzt - HLN Consulting, LLC - Public Member

Okay. Well, so that's sort of on the SSA thing. So, as I look at your Slides 2 and 3, which are, if I understand you correctly, showing as essentially the two different views of this problem, right, or of this example. I guess I have two things to say and you might find it odd that I'm arguing in this way. But first, it feels like, and ONC can comment or not, it feels like ONC's intent in TEFCA 2 is that we only have full QHINs. That's at least what I understood and have understood every time I've read this.

Arien Malec - Change Healthcare - Co-Chair

Yeah.

Noam Arzt - HLN Consulting, LLC - Public Member

That being said, it's not clear to me what is really gained by having a more narrowly functioning QHIN. So, you made a comment somewhere along the way well, it potentially saves a network hop maybe so Diagram 2 saves a hop over Diagram 3. But it's not that that's not without some expense because it's at the expense of never quite knowing what a QHIN is actually capable of because now everybody is not capable of the same thing. So, there is a complexity trade off in saving a hop in some cases. But now, you sort of have to have a more complicated map of what QHINs are and what they do. And I'm just not sure – certainly, it doesn't feel like it was ONC's intent. And I'm not sure that you really gain anything, to be honest.

Arien Malec - Change Healthcare - Co-Chair

Okay. So, I think you're right. I think you're definitely right that it was ONC's intent to have QHINs that are general purpose. The way that I would articulate the value proposition for the special purpose QHIN is less around saving a network hub and more around serving the particular needs of its customer set and getting specialized. Whereas the general purpose QHIN almost by definition will never really be able to concentrate on the needs of public health because of the general demands of being a full service QHIN. And the same kinds of –

Noam Arzt - HLN Consulting, LLC - Public Member

Yeah, I don't know that I accept that argument, frankly. A decent QHIN, if it can develop a business model for N + 1 service should be able to develop that service without distraction from its other activities. And if it can't, it's not a good enough QHIN.

Arien Malec - Change Healthcare - Co-Chair

Okay. I've got a perspective there but I will refrain from it and keep moving through the commentary. So, Mr. Kansky.

John Kansky - Indiana Health Information Exchange - Co-Chair

So, given that TEFCA 2 says not only that, as drafted, that QHINs serve all modalities and

purposes but it also says that all participants and participant members must sign on saying that they are also capable of all modalities and exchange purposes. So, the concept of the specialized QHIN didn't make or doesn't make sense to me unless what we're really talking about is allowing specialization of QHINs, participants, or participant members meaning allowing anyone in the TEFCA at any level of TEFCA to say I'm only participating in the following. And that is a dramatic potential change to TEFCA as drafted. I don't know that it's a bad change but it's a significant change.

And the last comment I'll say is that because of this discussion, Recommendation 7A and 7B have now been rewritten and 7B basically says kind of what I just said. And 7A, as written, says leave draft TEFCA as it is saying that all QHINs, participants, and participant members have to do all modalities and exchange purposes or no, Alternative B is even though it represents a compromise, it's a good compromise to make. Let participants, participant members, and QHINs pick and choose their exchange purposes and modalities.

Arien Malec - Change Healthcare - Co-Chair

Yeah. And in some cases, those exchange purposes and modalities may be constrained by information blocking and regulatory requirements as opposed to being constrained by the TEF – by accepting the MRTCs and being part of the TEFCA network, they pick and choose the exchange modalities that are relevant for their purposes. And for some of them, broader regulatory concerns like information blocking and other concerns like promoting interoperability, etc., move them in the direction of broader exchange purposes. Okay. Denise, David, Sheryl.

Denise Webb - Individual - Member

Okay. Can they put the diagram back up for No. 3, Model 3?

Arien Malec - Change Healthcare - Co-Chair

Yeah. Model 3 is the full QHIN model, yeah.

Denise Webb - Individual - Member

Okay. So, taking what Noam said and what John said, I agree that I think that ONC's intent was this idea of a single on ramp for participants and participant members that they could connect with a QHIN and that be their on ramp and their way of getting to information that's in other places through QHIN to QHIN communication. So, on this Model 3, what John was describing is this model, except he said that the QHIN would have the ability to specialize. I would like to suggest that ONC's intent was full QHIN, all exchange purposes and modalities. But where I think we need to recommend the change is specialization of members. So, a member could be this public health – excuse me, specialization by a participant of a QHIN. So, this public health aggregator could be one of these specialized HINs.

And it would not have to respond and take all of the flow down requirements to respond and do all exchange purposes and all modalities depending on what their specialization is. So, it's what John said but except the QHINs. The QHINs need to be full QHINs. So, that's the position I would take on this. This Diagram No. 3 really helped me kind of visualize this because like Noam said if a QHIN could do N + 1 and have the capability to do that

specialization around being a public health aggregator, great. They still have to do all the full QHIN. But if they don't then, one of these participants of a QHIN, if we recommend in our recommendations that we're setting forth that the flow down doesn't require those participant and participant members to necessarily accept all of the flow down. Is that making sense what I'm trying to say? I just –

Arien Malec - Change Healthcare - Co-Chair

No, it does. So, there's a perspective. So, you're agreeing with the perspective that participant and participant members should be able to choose the exchange the purposes and modalities that are relevant for their needs. And you're saying nonetheless, there is some value in having all QHINs support all needs to drive the ecosystem considerations that there be a few QHINs that really specialize in network to network exchange and maybe another editorial of your perspective is that it's the HINs that should do the specialization. And if they need to contract with a QHIN to do the last mile hop, so be it.

Denise Webb - Individual - Member

Right. And in this case, this EHR in this diagram would need to send data to go to the state based surveillance system for the states that this EHR vendor product is used in. And they would be able to have their single on ramp, the participant member who is using that EHR, would be able to have their single on ramp to send their data. It would go through the full QHIN that they're a participant of and then, over to the other. And it would travel down to this specialized aggregator. And I think to have QHINs where some are full and some are specialized like Noam says that gets extremely complicated to manage an ecosystem like that. And the same thing – the point about the Social Security Administration, if it's not appropriate either by law or it's just – and they're not subject to information blocking.

Arien Malec - Change Healthcare - Co-Chair

Denise, sorry to cut you off but there are three more people in the cue and I want to get through comments and see if we can get to a consensus opinion.

Denise Webb - Individual - Member

Okay. So, let me just say this. I'm in between A and B because A is not right –

Arien Malec - Change Healthcare - Co-Chair

Yeah. John Kansky is proposing a 7C that allows specialization to happen at the level of exchange participants and participant members that still requires QHINs to serve all needs. So, David.

Denise Webb - Individual - Member

Thank you.

Arien Malec - Change Healthcare - Co-Chair

Yeah.

David McCallie, Jr. Individual - Public Member

Yeah. I think that a compromise is possible where you have all QHINs have a minimum set of responsibilities that they must reply to and participate with the other QHINs on. But you could allow for individual QHINs to specialize above and beyond that floor so as to develop innovative and interesting new services that they could then make available to everyone else through the QHIN network. And I think that if you don't do it that way, you will lock TEFCA into this kind of, I don't know, mid 2015-ish view of Common Well and Care Quality 2013/2014 view of what national interchange is all about.

And you'll kind of lock it down. Everybody will do that one thing and it will be good but it won't be to grow and expand and innovators won't be able to create new capabilities that take advantage of the QHIN's knowledge of where patients have data and where their providers are because, in order to do something new and innovative, you'll have to convince every other QHIN to do it with you. And that seems highly unlikely. The process that the RCE uses to govern itself will almost ensure that that doesn't happen. So, I think you need an alternate model that says QHINs have a minimum set of required responsibilities. Those would include things like keeping track of who the members are and where their records are located, what their meaningful choice selections are, what the auditing requirements are, what the minimum security standards are and the stuff that we've discussed.

And they must support a minimum set of floor use cases, including reciprocal exchange, as we've discussed and then, allow them to carve out capabilities that go above and beyond that if there is an innovative idea or a business model or a drive to go do so in service of some otherwise perhaps neglected part of our health IT infrastructure. So, I think you can have both but I wouldn't want to lock it in to a mid-2015 view of the world, which is what's going to happen with the current proposal.

Arien Malec - Change Healthcare - Co-Chair

So, David, I think I would say that the current TEFCA agrees with you because I don't believe there are any constraints about what a QHIN can do above and beyond the TEFCA but that that floor is set at all exchange. Basically, the two forms of query and message delivery and all exchange modalities. And so, it's a –

David McCallie, Jr. Individual - Public Member

But we've already carved out, as you pointed out at the beginning, we've already carved out a special exemption for public health and a special exemption for IAS and maybe an exemption for social security. It is inevitable that this will not be everybody doing the same thing all places up and down the stack. We're creating special stuff already. So, we need a model that allows for that to happen and says there's a minimum that you've got to do and then, beyond that, you can specialize. That's what will lead to the universal on ramp because more and more services will say there is so much value in the QHIN knowledge of where patients have their data that I want to the participant.

I want to take on those minimum requirements and participate in that network. Otherwise, they'll have little incentive to do so.

Arien Malec - Change Healthcare - Co-Chair

[Inaudible] [00:28:02]. Sheryl, Mark and then, back to John.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Hi, this is Sheryl. First of all, I want to thank you so much for putting those drawings together because that's exactly what I needed to see in order to visualize it. So, I really appreciate that Arien and whoever else helped do that. But I do agree with what David just said and also what Denise was saying earlier that I think that as long as we're focusing on this, I think we add complexity by trying to recommend specialized QHINs. I do believe that the QHINs should be able to support a minimum as a floor and then, go up from there as technology and tools and techniques mature. And then, I also agree that participants should participate to the extent that they're able or capable. And so, some will be able to do more and others will only be able to do less.

And that would then support the notion of public health information agencies to participate to the extent that they're able and what they're able to do is gather information and not really share much. Although, some of them do share information for research purposes. And if that is set up for them then, there is no reason why they wouldn't be able to make that available if that becomes part of the purpose. And I'm sort of looking down the road. I'm sure you have all read that senate health legislation that's coming. But one of the components of it is a potential national APCD with ERISA data. And so, this may be a perfect opportunity to make that data available in that way for states to be able to hook up and be able to utilize that data if all of the requirements meet the necessary guard rails. So, that's what I think and thank you, again, for doing that because it really helped.

Arien Malec - Change Healthcare - Co-Chair

Excellent. Just to be clear, is that a vote for 7B or a vote for the Kansky 7C, which is QHINs have to do everything that participants and participant members can do different things?

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Yes.

Arien Malec - Change Healthcare - Co-Chair

Or maybe a vote for the McCallie view, which is there should be a core set of things that all QHINs have to do but we accept that there are going to be more things over time like research and those activities and references that all QHINs have to do everything at all times. And we accept that participants and participant members may accept a limited set of use cases. So, 8D, vote for 8D.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Yeah. I think I'm looking for a 7D because I don't believe that all members of all QHINs will be able to do all things. Let's face it. We have HIEs who collect data, share a certain amount of data for certain purposes. It's going to take them some time to mature to where we expect they're going to want to be. So, to me, the idea is to get them involved, have that single on ramp and then, as they're capabilities mature, they will continue to make those available. And the QHIN being, hopefully, the independent manager of that network is going to then at

least have the capabilities to continue to expand to be able to take on some of those additional capabilities as they become standards and mature as well.

Arien Malec - Change Healthcare - Co-Chair

Cool. All right. Mark and John. And I think now the consensus has swung to somewhere between 7C and 7D, which is good. And then, we may be in the position of majority/strong minority or we may be in the position of alternative perspectives that we'll put in one recommendation to represent the middle fence of the group. Okay, Mark.

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

I think I'm going to muddy your waters. I want to go back to what Denise was talking about, her description of why we needed QHINs doing everything but maybe some allowed specialization, the next tier below. And I appreciate the diagrams, Arien. I went back to the user guide and looked at the examples that they give of various use cases, which flow down a few more layers even below the HINs. And I think the same question comes up for me, which is if you have QHINs that are providing everything but the next layer down they don't, and I'll repeat the question I asked several calls ago, what happens if nobody does, if none of that next layer actually provides all things and you've got problems for the members and the participants down at the bottom?

You don't have a single on ramp. So, it may be productive to pull up some of the examples from the revised user guide and just test this understanding that it's going to actually work for the person at the very bottom for them to be able to use this interoperability system because, just as a thought about David's articulation on specialization, we've had a lot of that over the past 10 years. And one of the things that happened, for example, is we didn't get interoperability out of all of that specialization. And we had to come back in and create a single on ramp for that. I don't think the market is yet working in such a way that we can say specialization is going to meet all needs. And so, I'm probably still at 7A as a policy goal and some level of recognition of the complexities of getting there.

Arien Malec - Change Healthcare - Co-Chair

Okay. John.

John Kansky - Indiana Health Information Exchange - Co-Chair

Thanks. I want to acknowledge that this is a bit of a soap box comment that's pointed at least 51 percent at the ONC listeners. I think this is perhaps the question or the recommendation that will be the most deterministic of the future of TEFCA because I think as 7A as proposed, I understand the policy goal of we have to get a system that does all of this stuff. And if we don't tell everybody they have to do all of this stuff, we're not going to have everybody doing all of this stuff. I think a 7CD makes TEFCA so much more acceptable and implementable to get on board with so much greater variety of participants and participant members that it's a more prudent, long term path for TEFCA. That's it, soap box comment.

Arien Malec - Change Healthcare - Co-Chair

Cool. Noam and then, I'm going to probe for consensus and see if we can find something.

Noam Arzt - HLN Consulting, LLC - Public Member

Okay. Just real quick, I think it's important that we recognize the distinction between participants being able to do and only having to do a subset of stuff versus different participants doing the same activity differently. So, I think what we have today is the same activity, the same thing folks are doing differently. That's why we sort of don't have in the interoperability. But that's different than participants doing a subset of a whole set of things as long as the thing that they're doing is being done consistently across all participants, I think that makes more sense. That's perhaps just a ratification of the previous comments that were advocating, essentially, for a 7C/7D world as opposed to a 7A world.

Arien Malec - Change Healthcare - Co-Chair

And David makes an important point in the public comment that the one unique thing that QHINs do is maintain the choice of individuals and some kind of capability for record location.

Noam Arzt - HLN Consulting, LLC - Public Member

But it's only unique because they're required to. It doesn't mean other people can't, right. Be careful of that word unique.

Arien Malec - Change Healthcare - Co-Chair

No, I think the key point is that having a cohort of organizations that can do that in a common way adds ecosystem value to your point that the novelty here is a bunch of different people doing this in a common way. All right. David, you've got your hands up and then, I'm going to close debate. David, is that the mute button you're talking to?

David McCallie, Jr. Individual - Public Member

Sorry about that. It was. I was going to make my closing argument with the obligatory reference that, Arien, you will be very familiar with, too, the internet hourglass concept, which is to say that the internet works because there's a small number of services that are required of everyone. And then, specialization is allowed to emerge on top of that. And I think that's the model that we would shoot for here with TEFCA is a small set of required services and then, allow for specialization on top of that. Any exchange is better than no exchange. And if you guarantee that everybody's records are located and their identities are managed and their preferences are tracked and their audits are kept then, allow for 100 flowers of interesting interchange to bloom on top of that.

Arien Malec - Change Healthcare - Co-Chair

Okay.

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

So, David, what are the small set of services that everybody would have to provide?

David McCallie, Jr. Individual - Public Member

That's a great question. I think, at a minimum, it would be MPI and RLS and meaningful choice and the security standards and the obligation that you must interact with all of the

other QHINs if you have reason to believe that they know something about the patient on whose behalf you're operating. And I would –

Mark Savage - UCSF Center for Digital Health Innovation - Public Member
Are you speaking at the QHIN level, not participants?

David McCallie, Jr. Individual - Public Member
Yeah.

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

David McCallie, Jr. Individual - Public Member
At the QHIN level, I would go further and say reciprocal exchange for the purpose of building a federated record. Common Well and Care Quality, is also a minimum required service because that's the vision that's driving TEFCA. But we've already carved out some exemptions of that and said well, it doesn't apply to SSA the same way and it doesn't apply to public health exactly the same way. So, even that's not quite universal, although I think you could make a use case that's essentially universal for practical purposes. But that leverage is on top of the fact that the QHINs know how to talk to each other. They know who the patients are. They know where the records are and they know what the preferences of the consumer are.

Arien Malec - Change Healthcare - Co-Chair
Kansky.

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

Arien Malec - Change Healthcare - Co-Chair
Leftover, okay. So, what I'm hearing just as to poll the sense of consensus is I think there's broad agreement that different exchange participants and participant members may well need a different set of use cases. Some of those participants and participant members are constrained by information blocking to serve a wide variety of exchange modalities and exchange purposes and uses. Some there is value to forcing them open, even though they may wish to be closed. And for some, there's really no value to force them open. So, I'm not sure how we resolve that but I think there is a consensus for this isn't quite as simple as everybody does everything because we've already invented cases where not everybody does everything.

I think there is now consensus that there is a set of things that all QHINs should do. I think there is a consensus that all QHINs should serve the query aggregation and the holding of choices by the individual. And I also think that there is maybe not consensus but a reality that QHINs are not a single on ramp for all cases because, for example, direct based exchange, not general directed based exchange but direct based exchange is, I think, almost deliberately

being left out of the TEFCA. So, I think we're lining up somewhere around 7C, which is a reflection that there's a common core set of things that QHINs must do. There's value in having a common core set that is nationwide and ubiquitous. Maybe a recommendation that as we have additional uses and cases, we examine each of those to say is this something that everybody should do or is this something that it's okay for a limited set of participants to do?

And I also have an editorial comment that these conversations that we're having are 100 percent recapitulations of conversations that, for example, Common Well has been having as it's wrestled with these exact cases, which is what has to be universal for Common Well to work. And then, when actors want to come in and do a limited set of things, is that okay because that's appropriate for their cases or is that kind of subverting the rules of the network? And I'm not sure that these are things that the MRTCs can get right all at once. Anyway, that's just an editorial comment. So, I think we're kind of winding up around a consensus opinion. We're going to try to write it up and test it maybe on Friday and over the weekend. And then, hopefully, on Tuesday, we can come in and bless it. All right. I'm off –

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

Arien, can I just throw out a thought, which is to think about whether somebody should be responsible within this system of specialization to make sure that it's working overall. Maybe it's the RCE that makes sure that whatever specialization, it is an on ramp for all, a single on ramp for all and that they're managing that process and checking. Does that make sense?

Arien Malec - Change Healthcare - Co-Chair

It does.

David McCallie, Jr. Individual - Public Member

Well, it makes sense for them to measure it and report on it. I don't think there will ever be a single on ramp. There's too much exchange that happens. It will never be a part of TEFCA. So, we have to be careful about that.

Arien Malec - Change Healthcare - Co-Chair

I definitely agree with that. I'm going to propose we move on and go on to the next set of contentious topics that will be fun to discuss. Oh, boy. This is the best one. Here, I think we have framed up two perspectives. One carefully designed hopefully for a consensus opinion. But maybe we can't get there and we're going to have to have a split decision. So, let's line up on where this is. So, this is about individual access and what purposes individual access winds up doing. And I'm going to frame the difference and, again, Mark will be grumpy with this and that's okay. But there's a question now about may or must and what's required. But I think to be fair to Mark and maybe Mark can speak for himself, but 8A says the baseline floor for IAS is defined by HIPAA right to access and the HIPAA right to amendment or correction.

And IAS, you can't do IAS on the TEFCA unless you do both of those things. And then, a set of motion towards additional use cases. And I think there was some ambiguity about whether those additional use cases are – it would be unsatisfying to have none of those additional use cases or whether it's a true may. 8B, which is designed for consensus or designed for

compromise may not get there. It says ONC should establish a policy framework to reach broader individual services, including amendment, shared care planning, PGHD, and data donation for research at a clear timetable. ONC and the RCE should roll out individual services that are ready for large scale adoption starting immediately with IAS exchange purposes as described in Draft 2.

This constitutes a significant step forward for patient access. ONC should work with the RCEs and QHINs to develop and test additional forms of individual exchange within the timetable established for expanded usage. And that is hopefully a compromise position that can get consensus opinion. And David has his hand up. And I assume Mark is going to have his hand up soon, too.

David McCallie, Jr. Individual - Public Member

Yeah. I like the compromise position. I probably want to read it a couple more times more carefully. But on the first read, it looks good. And I think what we have to remember here is that TEFCA is a voluntary framework and that some of these very complex services that are already underway, payers and population health aggregator companies and others are addressing some of the kinds of things we're enumerating here and for them to be wooed over to TEFCA will require a lot of work and a lot of discussion and marketing, if you will, by ONC and the RCE. So, I wouldn't want to hamstrung the RCE and TEFCA to say you have to do all of these things on Day 1.

I think you should seek to do them but get started with the incredible value of a patient being able to get a single aggregation of their entire distributed record. That's very powerful as a starting point.

Arien Malec - Change Healthcare - Co-Chair

Okay. Mark.

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

So, just actually to jump onto David's last point, with IAS as defined, you won't get a single aggregation of all of your record because you only get a copy from each individual provider.

David McCallie, Jr. Individual - Public Member

Well, that's what I meant. You get the sum total of everything. It takes a physician to actually perform the aggregation. And you'd have to hire someone to do that, which is what a health record bank would do, by the way. But that's another debate.

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

So, I think I continue to like 8A. I think it actually is more specific about the urgency of the timeline where as 8B just sort of punts it down the road. And I go back to the user guide and the diagram of the individual access services where you have a patient using a smart phone app. And patients are going to want to use their smart phones for so much more than just requesting a copy of their record. You've got the Apple health efforts. People are wanting to use them for care planning. They're wanting to provide data back to their doctors. So, I'm still

with 8A.

Arien Malec - Change Healthcare - Co-Chair

And just on the clarification of 8A, do you intend the list described there to be optional? So, I clearly have the notion that we're starting with rights correction and individual access. But the other services there, do you intend those to be mandatory or optional at launch in your interpretation of 8A.

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

In my interpretation of 8A, may and must weren't there. It just said include. And it was in the spirit of this being a committee effort, it was productively ambiguous, I thought, about that. That list of three, in my mind, I tried to cull the things that are immediate and really important. Not everything, just the really important stuff. And if they're not ready at the outset, they really should be soon because people need them and people are clambering for them. So, if you put me to choose between whenever or now, I'd say now because that's what we need now. But I didn't go so far in the language drafted for the task force as a whole because I recognized the complexity of getting there.

Arien Malec - Change Healthcare - Co-Chair

By the way, speaking just as an individual editorial comment, somebody was recently hospitalized. The notion that I can get access to my data on my smart phone is a minor miracle. And if that were easier and more ubiquitous, I personally would see significant value in that and would consider it to be a significant step forward. But that's sort of N1 perspective informed by recent health experiences. Carolyn?

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

No, it's in NF2 because I agree. I'm just saying and we all need more.

Carolyn Petersen - Individual - Member

Yeah, this is Carolyn. Speaking for myself, I just want to note my agreement with Mark has just shared. And also, put out there a gentle reminder that it has been many years that patients who are supposed to be able to get all of the information from whatever providers are there with information and records. And I think we set the bar pretty low if we say that's what we should be looking for. People are doing lots of other things and it's time for industry and expectations to move on and go forward with that.

Arien Malec - Change Healthcare - Co-Chair

I am hearing a lack of consensus and a split decision. But Cynthia.

Cynthia Fisher - WaterRev, LLC - Member

Hi, Arien, hi, all. I don't know who spoke before Carolyn but regarding personal need and smart phones. I don't know if that was you, Arien. But I do believe that as we look at both 8A and 8B that we – yes, I agree with trying to get this as much as we can to the smart phone. And I think as we look at TEFCA and we look at the price transparency EO that just took place, I think what we want to do is also if we look at ideal smart phones and ideal cross exchange

of information, it would be what is the price before we receive care. What is our actual health information as a result of that care? And what is our payment information? Much like a close out on other apps that we use, all of that information, our EOB coming in dribs and drabs over weeks and months, sometimes even nine months after you get your care, could all be transformed over this backflow so to speak and exchanged.

So, I just kind of think as we look at this for the ultimate use of an individual, I think we want to make sure that the platform and the pipe of flow provides that the patient can have access and also be able to be directive and minimize maybe, to be able to cut out or minimize certain facets of exchange that they may choose not to have exchanged. We spoke of that the other day but I think we really need to look towards the optimal goal of deploying this information to the patient in an optimal way. And the patient also being able to deploy back correctively and responsibly **[audio interference]**. I think that could be very patient focused on its use rather than everybody else's use and optimization and capitalization on the patient date.

And that's a little bit of a concern of the tone of this entire effort has been on everybody's capitalizing on the effort versus really, it's about optimizing the patient care and diagnoses and decision making into the hands of the patient who is trying to control and navigate and advocate for themselves across the system.

Arien Malec - Change Healthcare - Co-Chair

Absolutely. And by the way, I'm just going to poke Steven Lane and tell him that I would pay his organization gladly today if I knew what I actually owed for my recent hospitalization. David McCallie.

David McCallie, Jr. Individual - Public Member

Yeah. It seems to me that the tension here is not around the question of the goodness and laudability of these requirements or these goals. The tension, in my mind anyway, is around whether TEFCA is the right channel to achieve them. And if it is or isn't, how much burden do you put on TEFCA to try? And I just feel like it's a little bit like requiring that all ice cream have no calories. It would be a goal we would all approve of but getting there may be a little difficult. So, we probably wouldn't say you can't sell ice cream until you get it to zero calories. So, I feel like we all want zero calorie ice cream. I'm just saying saddle TEFCA with a mandate that you have to have that before you can sell any ice cream. Bad metaphor, sorry.

Arien Malec - Change Healthcare - Co-Chair

Well, I'm reminded that class analogized Common Well to cold fusion. I don't think we're talking about things that are both culinary and physiologically impossible. This is the central debate. We're all inpatient. We all want more. We all want to get this done faster. I think we're all – I think Carolyn's point is spot on, which is come on, guys, the floor has been the floor forever and we still haven't gotten there yet. So, let's stop making the floor the floor versus if the floor is the floor and we haven't gotten there, it just means we need to try harder. And I'm not sure that there is a magic answer that's going to be the right compromise between those two positions. So, I think we need to draft a recommendation that acknowledges the urgency of this issue and acknowledges the tradeoff.

Cynthia Fisher - WaterRev, LLC - Member

Well, Arien, we can do better than status quo. I think that's – we're not talking about anything novel that's going to – this is not going and putting a person on the moon or sending them to Mars. This is actually – there is feasibility and I also would like to make an emphasis that a lot of it is about sharing a lot of this data within systems and within organizations. And come on, let's be real. There's a race to AI. There's a race to big data. There's a race for research. But at the end of the day, this is about the patient. And I think the patient focus of what the patient needs in getting this individual access is what's really foremost to deliver and allow to have control of their own health information for one, which I think that we can do that through TEFCA. And I think it is reasonable.

And then, I think there are other avenues that we want to lay down the road and lay down the pipes to say hey, guys, you do this in every other facet. Let's make sure as we're sitting on the HITAC hat and we're sitting on the TEFCA hat wearing those hats on these committees, what are we doing that we're going to be able to deliver near term and stop having the protectionism and the blocking of the sharing that's been in place for entities growing and keeping patients within their own system. So, we want to deliver it and I just think our tone is really meant for – needs to put the patient first and our avenues of laying the groundwork. It's an opportunity in time to do the shift. And I'm sorry, but just talk the way into the patient.

Arien Malec - Change Healthcare - Co-Chair

Super well said and I think you'll actually find a ton of agreement. And I think there's actually going to be a fair amount of consensus and, as I said, maybe just a little bit of wordsmithing around the edges. All right. We are going to draft a consensus opinion here. And we'll move on to our next contentious topic. I think we're good there. I think we're fine here. I think we got the consensus last time on that topic. Meaningful choice. Okay. I actually think we're okay on meaningful choice.

John Kansky - Indiana Health Information Exchange - Co-Chair

That's where we started last time, right?

Arien Malec - Change Healthcare - Co-Chair

Yeah.

John Kansky - Indiana Health Information Exchange - Co-Chair

So, we've lapped ourselves.

Arien Malec - Change Healthcare - Co-Chair

Okay. So, is 12 our next big, contentious topic?

John Kansky - Indiana Health Information Exchange - Co-Chair

I'm thinking.

Arien Malec - Change Healthcare - Co-Chair

Or do we have a consensus opinion for 12? This one, we're just going to have to vote on it and get to majority strong minority.

John Kansky - Indiana Health Information Exchange - Co-Chair

I'm thinking out loud, which I should never do on a committee but we had notes from last time that I'm trying to remember if they did anything to move this particular cheese or if we have the cheese we have.

David McCallie, Jr. Individual - Public Member

Ice cream, cheese.

John Kansky - Indiana Health Information Exchange - Co-Chair

Yeah. I missed lunch so it all sounds good.

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

Pull up some old copies. I just want to check and make sure that, Noam, I think there was a change on the Recommendation 10.

Arien Malec - Change Healthcare - Co-Chair

Yeah. The change we made here is one that I believe addresses the consensus opinion, which is the consensus opinion around noting that particularly surveillance should not respond to query. And then, we put in the discussion points rather than the recommendation the notion of the debate that we had around immunization registries, again, without clearly putting in a recommendation. And I feel like, on the last discussion, that was exactly the compromise position that we agreed to get to. So, I'm thinking – Laura, go for it.

Laura Conn - Centers for Disease Control and Prevention - Member

Just a little bit of wordsmithing on 10 where it says primarily exists for disease surveillance and do not maintain patient centered data. Most disease surveillance systems are patient centered so I don't think you want to combine those two thoughts.

Arien Malec - Change Healthcare - Co-Chair

Yeah. So, I guess what I mean is the purpose of – you know way more about this than I do so I say this with some advisement that the general purpose of the disease surveillance is to provide aggregation and signal detection, not to maintain a longitudinal patient record on behalf of the patient for the patient's discovery.

Laura Conn - Centers for Disease Control and Prevention - Member

That's definitely true. But they are a lot of patient individual surveillance systems – sorry, Noam, go ahead.

Noam Arzt - HLN Consulting, LLC - Public Member

No, I was just going to say there's a wide gap between aggregate level data and a longitudinal record. And these surveillance systems are off somewhere in the middle where they're definitely patient specific but in the context of an outbreak or an event. So, it's not longitudinal. So, it's not sort of forever but it is patient centered. So, Laura is right. This should be accurate.

Arien Malec - Change Healthcare - Co-Chair

Well, it's not longitudinal – yeah.

Noam Arzt - HLN Consulting, LLC - Public Member

Do not maintain a longitudinal patient record if that's what you're trying to distinguish.

Arien Malec - Change Healthcare - Co-Chair

Perfect.

Noam Arzt - HLN Consulting, LLC - Public Member

That I think is more accurate now and I think makes the point that you're trying to make.

Arien Malec - Change Healthcare - Co-Chair

Yeah. Perfect. All right. I keep getting locked out of my own system because it's got a password that I only store on my password safe and I don't know how to type it. So, just give me a second to log in to my own system.

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

John, what were the notes that you were thinking of? I'm trying to pull up an old –

John Kansky - Indiana Health Information Exchange - Co-Chair

Yeah. I had the time to restore this in RAM. I think on 12A and 12B where Arien was going is correct. I think we've got what we've got and we need to figure out if it's a 50/50 or a majority/minority.

Arien Malec - Change Healthcare - Co-Chair

Yeah. So, recognizing I'm going to say something controversial but it's true, recognizing there is no nationwide right to be forgotten for patient data out of a sort of HIPAA compromised perspective that providers need to maintain a longitudinal health record and need to have litigation defense and for all of the reasons why once the provider has it and makes clinical decision about it needs to maintain in the chart, that's kind of the universal floor of the HIPAA land. And it may be advisable to have a – so I'd say the argument for 8B is that while it may be advisable to have another nationwide privacy law, that's probably the appropriate action of congress, not of the TEFCA. And where the TEFCA stands, which is really what 8B says, is appropriate as Perspective 1. Perspective 2 says that this right to be forgotten is critical and key.

Every system in practice has to already adhere to **[inaudible] [01:07:46]** and state based sensitive data handling requirements. So, there's no real lift to requiring tagging, segregation, and others. And if the patient says I'm out, even though something was done and incorporated in the chart, it should only be incorporated in the chart for historical reasons and not for going forward reasons. I suspect we've had enough debate on this topic and I would suspect we'd want to go to formal voting just to poll for consensus. Rest assured, Mark, Cynthia, for those who feel very strongly about this issue, this will either be a split decision or a majority position with strongly held majority/minority view perspective. So, for those on the phone, can we ask that we go through our role call just to be clear about the voting?

Say 12B, if you believe that an exercise of meaningful choice not to participate in the TEFCA by a patient should control future exchange but not the disposition of data that has been previously accessed and incorporated into, for example, a clinical chart. And then, say 12A, if you believe that such data should be tagged and labeled not for redisclosure following the exercise of an individual's meaningful choice not to participate in the TEFCA.

Noam Arzt - HLN Consulting, LLC - Public Member

Arien, do you have an opinion about what you think TEFCA 2 says now? In other words on –

Arien Malec - Change Healthcare - Co-Chair

What TEFCA 2 says now, yeah. The baseline is 12B.

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

Okay. John Kansky?

John Kansky - Indiana Health Information Exchange - Co-Chair

I'm 12B.

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

Arien.

Arien Malec - Change Healthcare - Co-Chair

I'm 12B.

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

Carolyn Petersen.

Carolyn Petersen - Individual - Member

I'm 12A.

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

Aaron Miri is not here still. Sheryl Turney.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

I'm 12B.

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

Sasha TerMaat, did she log on?

Sasha TerMaat - Epic - Member

Yes, I'm here. I'm 12B.

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

Thank you. How about Steve Ready? Cynthia Fisher. Are you abstaining, Cynthia? No answer. Anil Jain. Andrew Trustcott, he's not here. Denise Webb.

Denise Webb - Individual - Member

I'm 12B.

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

David McCallie.

David McCallie, Jr. Individual - Public Member

I'm 12B.

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

I'm 12A.

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

Noam Arzt.

Noam Arzt - HLN Consulting, LLC - Public Member

I think 12B but I wish I had more time to think about it.

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

Grace Terrell.

Grace Terrell - Envision Genomics - Public Member

I'm 12B.

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

And Laura Conn. Laura, are you not voting?

David McCallie, Jr. Individual - Public Member

I think she left.

Arien Malec - Change Healthcare - Co-Chair

Laura had to sign off.

David McCallie, Jr. Individual - Public Member

There was a note in the chat that she had to leave.

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

Okay.

Arien Malec - Change Healthcare - Co-Chair

So, right now –

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

Nine for 12B and one for 12A.

Arien Malec - Change Healthcare - Co-Chair

Who was the last one called before Laura?

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

Laura Conn was the last one.

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

Who was right before Laura?

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

Designated Federal Officer
Grace Terrell.

Grace Terrell - Envision Genomics - Public Member
It may have been me, Grace Terrell.

Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead
And what did you say again?

Grace Terrell - Envision Genomics - Public Member
I said 12B.

Arien Malec - Change Healthcare - Co-Chair
Yeah. So, we're going to write it up as 12B as the task force recommendation with a strongly and passionately held position for 12A. And sorry to do voting. Of all of the forms of consensus, it's the not nicest. It's the least consensusy. But I think, at this point, that's kind of where it was. All right. John, remind me where else we have issues that are significant that we need to discuss and get to with a full group.

John Kansky - Indiana Health Information Exchange - Co-Chair
Yeah. Just so there is no confusion, did we finally – it took several tries by me with help from others but I think we got to an explanation of our 12 plus 1 and that there isn't any controversy there. It's more of a correction than anything but I wanted to make sure people didn't get to this on the weekend, read it and go what the heck was this. It's don't change the usage rights of data. It's, basically, if 12B is our recommendation then when a patient exercises their meaningful choice that doesn't change permitted uses and disclosure of their data just that you can use and disclose. It should be the same before and after. That's all that's saying.

Arien Malec - Change Healthcare - Co-Chair
Right.

John Kansky - Indiana Health Information Exchange - Co-Chair
Okay. Yeah, that's a clarification so we're okay there.

Arien Malec - Change Healthcare - Co-Chair
I feel like we did a good job today. I feel like we got through the big controversial issues and I feel like we're ready for a proposed final draft. I feel like we've got a good sense of the status of the task force in areas where we're split, in areas where there's true consensus and where there's a strong minority opinion. So, I feel like we're in a good place for a final draft. If anybody on the phone believes otherwise that there are some things that they hold very strongly that we haven't gotten to, we probably should discuss them now. Otherwise, I would want to honor the directive for federal employees to take an early holiday and enjoy

the fourth and let the rest of the task force members do the same for those of us who aren't on the west coast and have large amounts of time ahead of us.

John Kansky - Indiana Health Information Exchange - Co-Chair
Can we do early public comment before we go to –

Arien Malec - Change Healthcare - Co-Chair
Yeah. We have the – I love the system of just flashing up and reminding me that I need to be thinking about it. Let's go to public comment and then, Mark –

John Kansky - Indiana Health Information Exchange - Co-Chair
Mark has a question, yeah.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Operator, can you open the line?

Operator
If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star key.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Are there any calls?

Operator
There are no comments at this time.

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

Arien Malec - Change Healthcare - Co-Chair
Cool. Mark.

Mark Savage - UCSF Center for Digital Health Innovation - Public Member
Can you either remind me where we landed on alignment with the API requirements and the ONC rule or scroll up so that I can just do that section again? Either way.

Arien Malec - Change Healthcare - Co-Chair
It's a good point. My impression that but it's also my bias because it's my select opinion is

that we got comfortable with the notion that we want to focus the energy – and I think this last discussion about IAS is also really helpful. I think we want to focus and maybe this isn't written up in the final recommendations but I'd say we want to focus the functional requirements and use cases for patient access better so that they're not just about exercising the HIPAA right to access but also exercising some of the functional requirements of that access, including aligning around the use case of hey, I'm on my mobile device.

I want to self-aggregate my own data and that that should be easy to do and that TEFCA helps me accomplish that task so that we're not mistakenly going to document based exchange with view only content that isn't incorporable in, for example, the Apple Health app. So, that's a long, clumsy way of saying what I think that consensus point out of that discussion was we want to tighten up our functional requirements, particularly for individual access so that they start with the end in mind in terms of the experience that we all want to achieve as individuals and that we defer the technical specifications about whether it should be a Fyre based API or a document based repository, query, or what have you to the QTF. That's probably a better policy decision to land up on. So, I'm going to pause there and see if that makes sense. And Mark, when you're done, David has his hand up, too.

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

Okay. I guess, in the interest of time, what I'd like to do is send some suggested language for this and for, however – and I can send it to the group. I can send it to you, Arien and John and Zoe and you can incorporate it. You just tell me how you want to do it. Why don't I just do that and we can see where that goes?

Arien Malec - Change Healthcare - Co-Chair

That works. David.

David McCallie, Jr. Individual - Public Member

Yeah. One other area that we haven't spent much time on and maybe we chose just not to but the question around direct messaging or directed messaging. Did we need choices there or are we going to capture some sense that some of us think that's a bad idea for TEFCA to take on? I know we had –

Arien Malec - Change Healthcare - Co-Chair

I actually think Noam articulated a perspective that I think should be explicit in the TEFCA. And it's ambiguous because the TEFCA talks about QHINs as a single on ramp. And yet, it also doesn't incorporate direct messaging or coordinating transitions of care, for example, as a use case, which is the predominant use case that direct trust is taking on as its technical enablement. And I think Noam made the point that direct messaging and direct trust are, in many ways, probably not orthogonal but parallel to the TEFCA and to the RCE.

And I think that's something that either you think the QHINs should be a single on ramp and, therefore, you absolutely need to incorporate direct trust and directed exchange into the trusted exchange framework or you give up the notion that QHINs are a single on ramp and acknowledge that there are these other important parallel functions where, in effect, direct trust is the RCE for directed exchange and the selected RCE, whatever it may be, is the RCE

for the forms of exchange that are articulated under TEFCA. So, I'm just going to pause there and say is that a statement of principle that we should be putting in our recommendations.

David McCallie, Jr. Individual - Public Member

I didn't follow. I think that's a statement of the problem. What's the principle?

Arien Malec - Change Healthcare - Co-Chair

The principle is ONC should make that clear, articulate that principle, and acknowledge that QHINs are not a single stop shop, single on ramp. That, in fact, the QHINs and the RCE have a parallel function in direct trust or directed exchange.

David McCallie, Jr. Individual - Public Member

And it may be that if that's the case then, it might not make sense to make one of the required use cases that everyone who connects to TEFCA must reimplement a parallel system to direct. I would argue vigorously but that's my small view. I would propose that we capture some sense that that's an unresolved issue. And if we went down the specialized QHIN notion and direct nodes could be thought of as QHINs, that's a possibility. There are a variety of ways to think about it. But simply saying we didn't cover everybody so let's start over and implement a brand new directed exchange network using even more outdated technology just doesn't make a lot of sense.

Arien Malec - Change Healthcare - Co-Chair

Yeah. By the way, I do not see message delivery as being an analog to direct or placement for direct. And I also think that needs to be really clear. I see message delivery as primarily what it is on the e-health exchange. It's primarily public health messaging.

David McCallie, Jr. Individual - Public Member

It's not described that way.

Arien Malec - Change Healthcare - Co-Chair

I know. So, I think that's something we probably should be explicit about.

David McCallie, Jr. Individual - Public Member

I agree.

Noam Arzt - HLN Consulting, LLC - Public Member

Keep in mind that we think of public health messaging when we talk about the directed exchange. But there's this other huge volume of ADT notifications that drives a lot of HIE activity that's another example of this, right. So, it's not just a public health thing. And I guess the notification services stuff probably by volume is much more than public health messaging.

David McCallie, Jr. Individual - Public Member

And I couldn't agree more that ADT notification is hugely important. But I would not address

it with XTM messages and the proposed notion that –

[Crosstalk]

Noam Arzt - HLN Consulting, LLC - Public Member

But we've already punted the QTF aside. So, don't get distracted by any particular technology. It's the notion of push functionality.

David McCallie, Jr. Individual - Public Member

We tossed it aside. ONC hasn't yet made that so we have to –

Noam Arzt - HLN Consulting, LLC - Public Member

No, no, I understand. But in the context of our recommendation, we've pushed that aside.

David McCallie, Jr. Individual - Public Member

I would argue that ONC should clarify the use cases for the messaging and suggest that development of use cases that address gaps is a perfectly appropriate thing for TEFCA but I would question the need for a universal replacement for direct. And taken that way –

[Crosstalk]

Noam Arzt - HLN Consulting, LLC - Public Member

But it's as a replacement for direct because you interpret that – and you and I have had this conversation offline because you believe that direct is the answer to push notification when, by and large, from a public health standpoint, it doesn't use direct for that purpose. It could, granted but it doesn't.

David McCallie, Jr. Individual - Public Member

So, we should start over?

Arien Malec - Change Healthcare - Co-Chair

Hey, everybody. Hold up. First of all, we have to get to Steven Lane. Secondly, I think the consensus here is we have this message delivery exchange modality. And then, we've got a bunch of exchange purposes. I don't remember reading in the MRTCs the functional requirements around message delivery and what it's supposed to be good for. And I think that lack of clarity – and maybe we just all don't understand query is supposed to be used for and we don't understand what message delivery is supposed to be used for. It's that lack of clarity that maybe is causing some of this ambiguity. So, I think it would be useful to put into the recommendations a recommendation to ONC to kind of clarify the boxes here. Steven Lane.

Steven Lane – Sutter Health – HITAC Member

Thank you, Arien. And thanks for the opportunity to sort of crash your meeting. And I just really appreciate the discussion that's been going on here. And I think it points out that there

are multiple use cases that are supported by push messaging. That there are multiple technologies existing, old, hopefully new, eventually, in the days of Fyre that could support those use cases. Since the very first day I walked into HITAC, I have been of the opinion that we should be collectively looking at push and pull as equivalent parts of the conversational nature of interoperability. And I think that leaving message delivery and push outside of TEFCA to live in some other universe just doesn't make sense. I think this is our chance to really put together a comprehensive trusted exchange framework and we appreciate it's going to take time and it's going to initially be voluntary, etc. But what we want is an ecosystem that allows support to communication and exchange of data.

And sometimes, you're pushing it. Sometimes you're pulling it. And it should all, in my opinion, be under the same umbrella. There should be a single on ramp. And for providers, patients, payers, all of the stakeholders, public health, we should look to the future of having it all integrated into one ecosystem. Thanks.

David McCallie, Jr. Individual - Public Member

Does that mean we should navigate for pulling ERX and claims submission? There are 100 other exchange modalities that drive healthcare today that involve patient data flowing. If it's a single on ramp, we've got a lot more work to do than just pulling in direct messaging.

Arien Malec - Change Healthcare - Co-Chair

Yeah. So, I'm going to do a process check. I think we're at time. And I think we launched into – we have a whole half hour left. Maybe that was a little hopeful that we were at time. Artificial consensus through artificial admitting of the time for discussion. So, I hear the discussion. I think in our last recommendations letter, we very clearly expressed the point that there are multiple forms of exchange and exchange modalities and we recommended that ONC clarify what it meant by single on ramp because it seems infeasible even to specify it to b a single on ramp for all of the things, including ERX networking, medical administrative transactions, pharmacy administrative transactions, directed exchange, etc. So, I think that's consistent with our previous recommendations.

And it sounds like we should mention something about the place of direct/indirect trust as a specific example but also, potentially, acknowledge some of these other purpose built exchanges that are up and running and in continuous operation. John, do you have any brilliant insight for me?

John Kansky - Indiana Health Information Exchange - Co-Chair

Sadly, no. I was going to pile on a little bit with David in that I appreciate Steven's perspective but I think there is a whole world out there. So, no, no particular resolution.

Arien Malec - Change Healthcare - Co-Chair

Okay. Can I propose and test to see if there is a strong objection that we – it's late in the day for us to be getting into this issue. I am going to propose some language in the next draft. The intent of that language will be to acknowledge this is an issue, to acknowledge that the task force discussed it and to acknowledge the task force discussed it late and didn't get time for formalized recommendations. And then, point that to our previous recommendations as

a task force as being the appropriate statement to make here. And I just wonder whether that's a perspective that people can get behind or at least get tired enough to not dispute.

John Kansky - Indiana Health Information Exchange - Co-Chair

Arien, I think under the circumstances that is better than leaving it out of the letter and I support that approach.

David McCallie, Jr. Individual - Public Member

Arien, it's David. That sounds great to me as well. I think another point you could add to what you've summarized there is this notion of addressing unmet needs as new use cases that TEFCA could go after because there are clearly some unmet messaging that could be useful and TEFCA should address them and see if they have a solution. So, it's part of the expansion addressing unmet needs for nationwide exchange, which could include some use cases such as public health ones that we've discussed as well as emergent new ones that are not well addressed by existing exchange modalities.

Arien Malec - Change Healthcare - Co-Chair

Okay.

David McCallie, Jr. Individual - Public Member

Plow new territory rather than re-plow old territory. I guess maybe that's the metaphor. I'm full of metaphors today.

Arien Malec - Change Healthcare - Co-Chair

Okay. Given that discussion, I am going to propose that we end the call early. We've done great work today and we have another meeting lined up for Tuesday. We'll try to get a draft out of the recommendations. Mark has offered to submit some language relative to tightening the functional requirements around patient access relative to his comments on APIs. So, for those who can't make Tuesday, please get your comments back over the weekend. And we have to close on Tuesday so, we're going to have recommendations and we're going to present those recommendations to the TEFCA. And I do believe we've got clear consensus and we're down to T's and dots on I's and brand new issues that we're bringing up.

So, I feel like we're in a pretty good place. John, anything you want to add or any other perspectives?

John Kansky - Indiana Health Information Exchange - Co-Chair

Just a question to you and to Zoe. So, other than the comment you just made for those who are missing Tuesday, is there any ask of the task force over the next four days?

Arien Malec - Change Healthcare - Co-Chair

I believe the ask of the task force with the exception of Mark's volunteering for language around the place of APIs is for you and I and Zoe to do a quick turn and then, for the task force to watch for our email and read and respond and get prepared for Tuesday.

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

And, Arien, this is Mark. I'll send the language when we get off of the phone. If anything is sent to me Friday, I will be able to look at it and turn it back by Friday but not Saturday. You'll work with whatever timeline you've got. I'm just being clear about what I can do.

Arien Malec - Change Healthcare - Co-Chair

Okay. Cool. Without objection, we will end the call early and everybody have a happy fourth.