

Carequality Query Workgroup Meeting

Accelerating seamless, interoperable health information exchange

December 15, 2014
2:00 – 4:00 PM EST



Agenda

- | | | |
|---|---|-------------|
| 1 | Review agenda/ identify new business | 2:00 – 2:05 |
| 2 | Meeting Minutes Review – Network
Presentation Sessions | 2:05 – 2:10 |
| 3 | In-Person Meeting Quick Recap | 2:10 – 2:30 |
| 4 | Call for Participation Review | 2:30 – 2:45 |
| 5 | Identifying Technical Teams and Infrastructure-
Discuss Expectations | 2:45 – 3:45 |
| 6 | Review Information Exchange Scenarios and
Discuss Test Data Strategy | 3:45 – 4:15 |
| 7 | HIMSS Presentations Materials – Booths,
Marketing Communications | 4:15 – 4:30 |
| 8 | Next steps, Other Business | 4:30 – 4:45 |

Quick Recap Highlights from In-Person Meeting

Work Group & Participant Introductions

#	Representative	Organization	Representative Group
1	Marty Prah	SSA	Governmental
2	Seth Selkow*	Kaiser Permanente	Healthcare provider organization
3	Sean Turner	Dignity Health	
4	Tara Dragert	Surescripts	Network
5	Justin Stauffer	Epic	Vendor
6	Hans Buitendijk*	Siemens	
7	Tone Southerland	Ready Computing	
8	David Schramm	Mirth	
9	Adam Rabinowitz	ManTech	
10	John Donnelly	Interoperability Domain Expert	Subject Matter Expert
11	Eric Heflin	Healtheway	
12	Joe Lamy	Aegis	
13	David Tao	ICSA	
14	Bob Robke	CommonWell Health Alliance	

* Co-Chair

In addition to the representatives noted above, representatives from the Commonwell Health Alliance, eHealth Exchange, and EHR- HIE Interoperability Work Group (IWG) shall be invited to participate in the Workgroup in a non-voting capacity.

Workgroup Co-Chairs have the discretion to engage other stakeholders and subject matter experts as the co-chairs deem necessary.

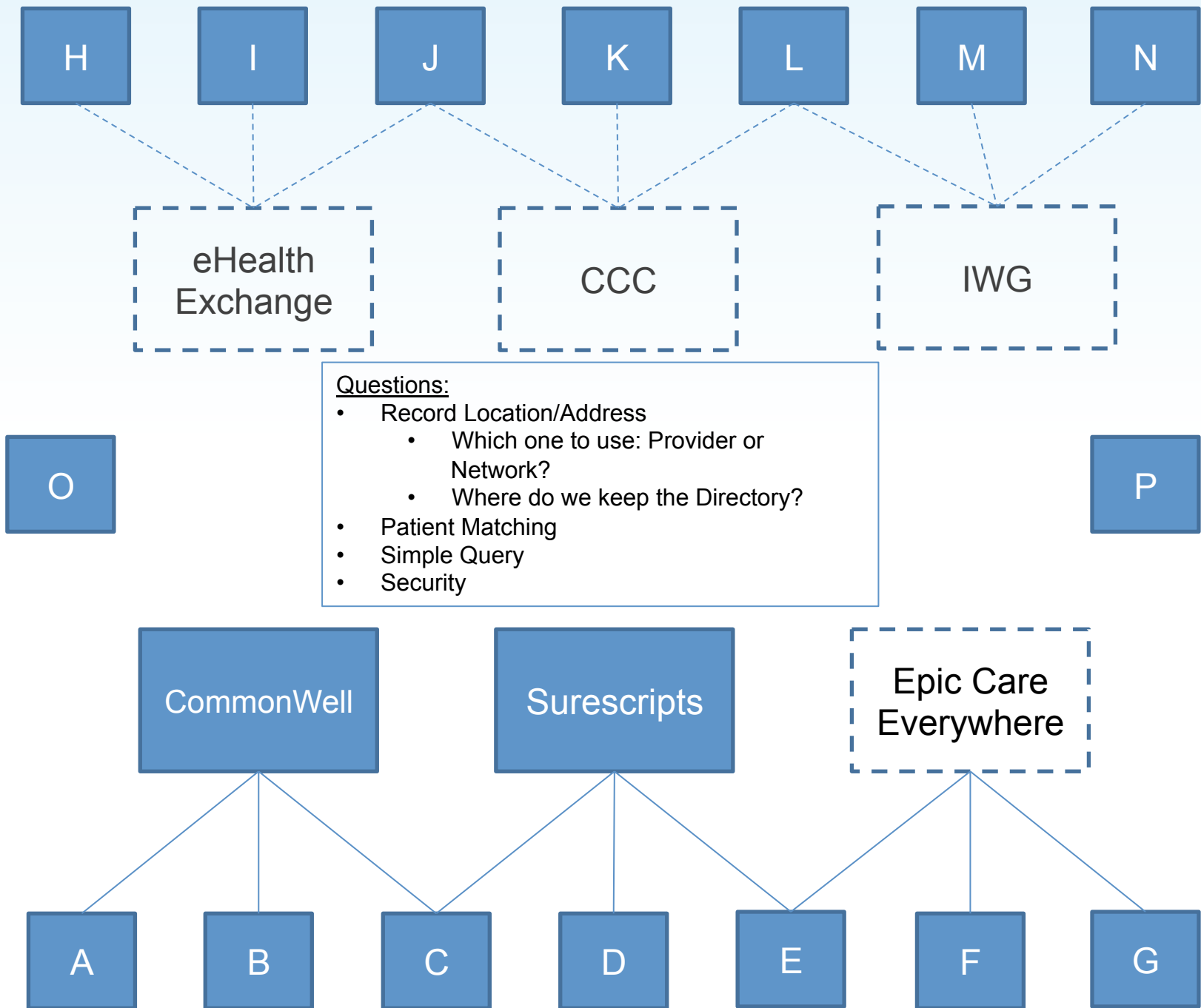
Objectives for Today

- Prepare and Set Path for Patient Discovery, Query, Retrieve Implementation Guide Draft by End of January
- Set Course for Connectivity Across Networks
 - Review Protocols
 - Review Data Elements
 - Draft Approach for Patient Matching
 - Analyze Commonalities and Variances Across Networks
 - Discuss “Virtual Connectathon” Approach and Set Goals for Upcoming Weeks
 - Confirm Participants for “Virtual Connectathon”
- Plan
 - Content
 - Business Side (Demonstration, Production)
 - Testing ?

To prepare for HIMSS Demonstrations

Content Focus

- Content
 - Already issue with push of documents with content. Can we rely on that being resolved?
 - Decision: Focus on metadata definitions, e.g., filtering options, not on the actual document content.
 - Basic, any document (e.g., c-cda, pdf, ccr, etc.)
 - Metadata Filtering (e.g., document types, date range, access control, etc.)
 - Perhaps staging.
 - Establish value sets, progressing from simple to harmonize to more difficult.
 - But at least list value sets content for each network that then can be used.
 - Content Filtering (e.g., sections, presence of diagnosis/problems, etc.)
 - Can we do this, or does it violate document conformance?
 - Does this represent data element level query? No, need to deal with large documents and have a roadmap.
 - Leave this to local filtering by the recipient.
 - Decision: Roadmap and becomes use case specific. Acknowledge in table of content.
- Behavior inventory
 - Document at least what one receives based on network given a particular query.



Potential Query Workgroup Focus Areas

- Query/Response
 - **XCA/XCPD (Current Focus)**
 - MHD (FHIR)
- Pub/Sub
 - Future potential
- Edge
 - Direct for Query – Future potential

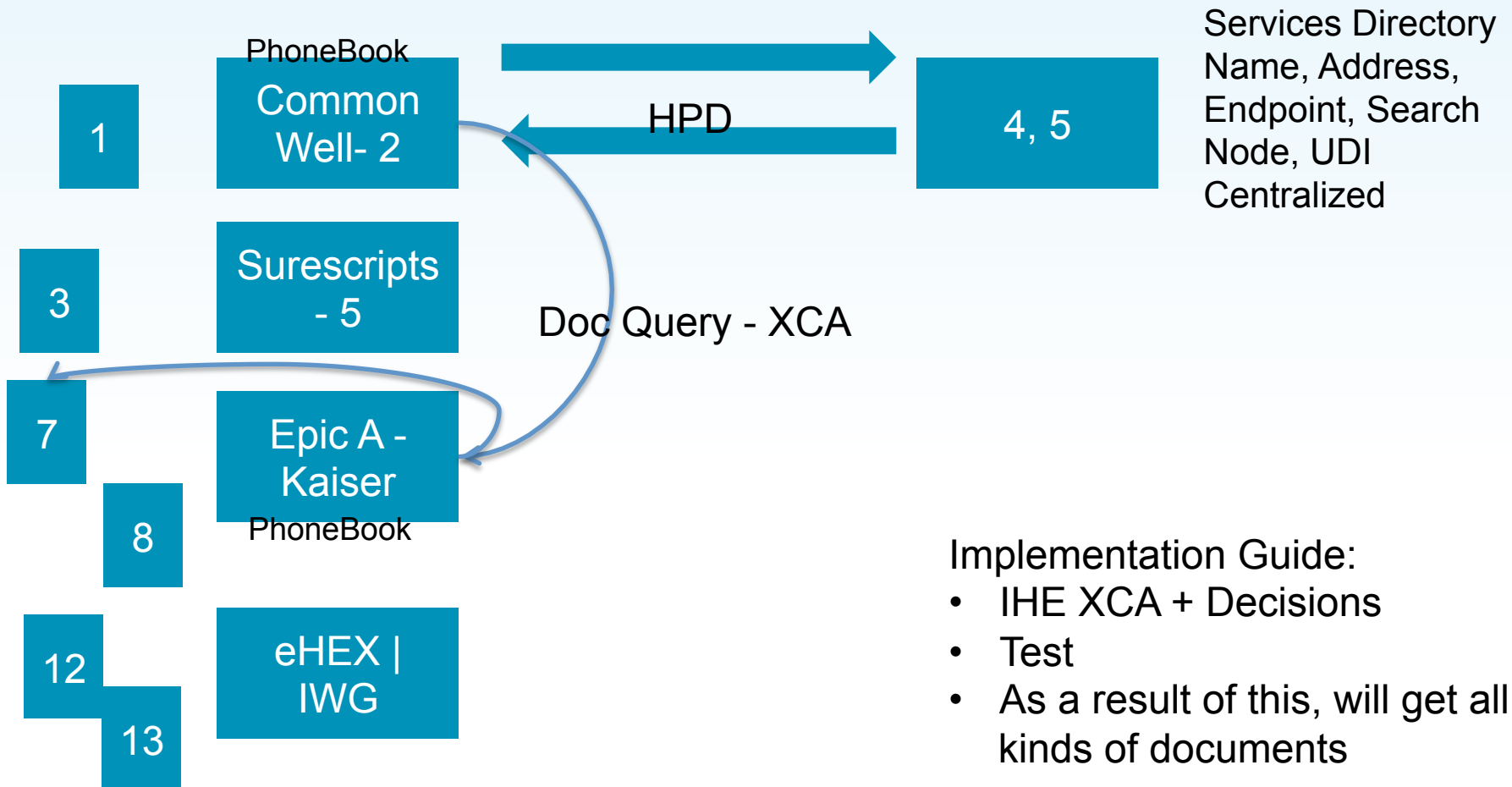
Security and Access Control

- Do we want the recipient of the receiver want to make access control decisions?
- Gap in exchange today to on how to respond to provide access or not.
- Have not defined how identifiers are used.
- Do we need to trust fabric, certifications, authentication, etc.
- Do we need a single CA? Network model?
- Decision: Stub it out and run it parallel.
 - Need technical framework and policy.
- Progressively flesh out models from “none” to
- Target: if onboarded to Node A, then onboarded to Carequality.
- Two aspects:
 - Underlying security (authentication, encryption, etc.) – Start with two CAs as multiple CAs are most likely; cross-certified with Federal Bridge; level of assurance; two FBC CAs can do these; Entrust, Digicert.
 - Access Control: Eric to provide overview as starting point.

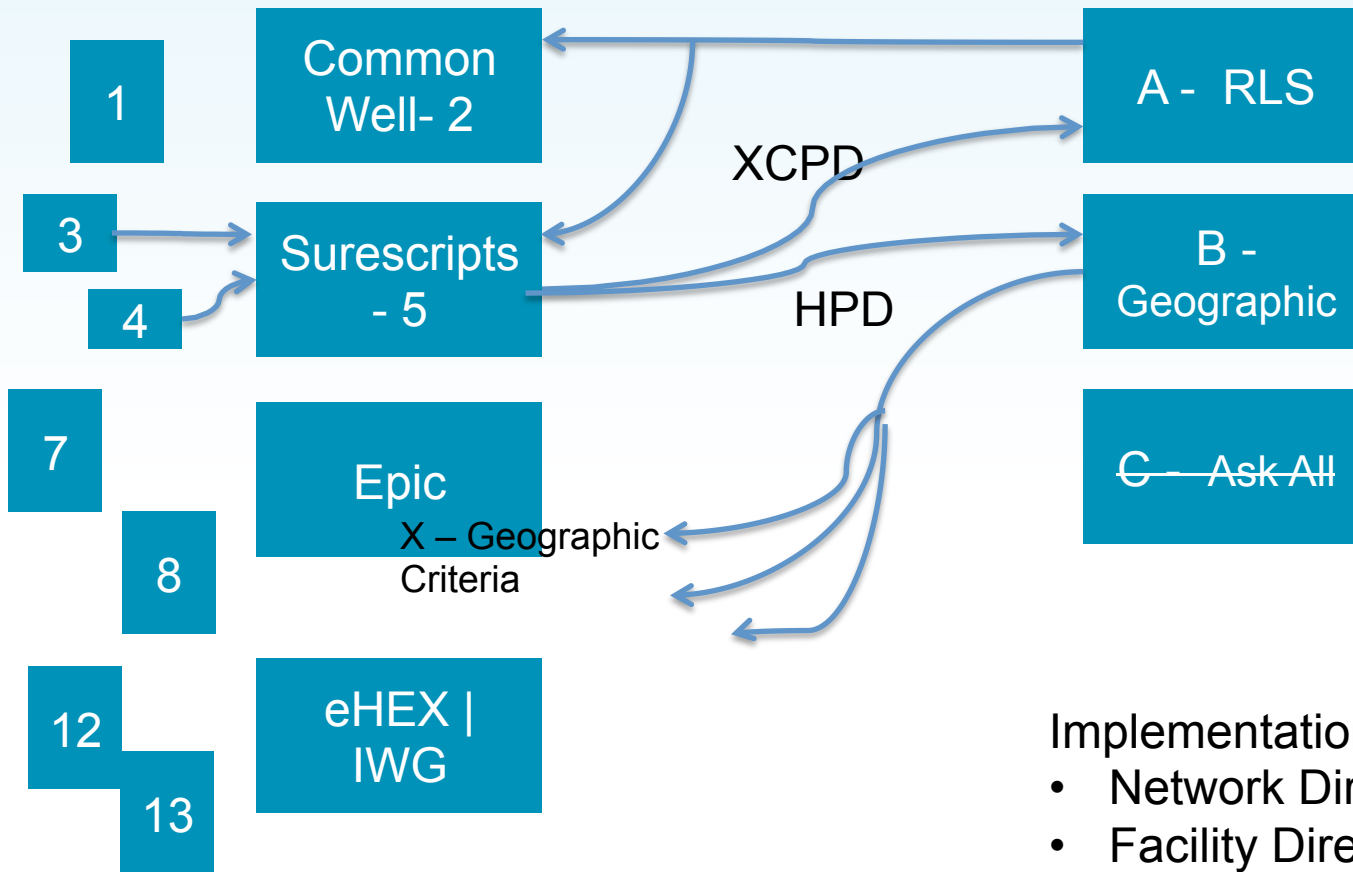
Approach

- Scope:
 - XCA - minimum
 - XCPD
 - HPD and/or XCPD for RLS
- Presentations
- Virtual Connectathon
 - Healtheway can help facilitate the infrastructure.

KNOWN LOCATION, KNOWN PATIENT



UNKNOWN LOCATION, KNOWN PATIENT



Services Directory of RLS, a node that is a RLS, Algorithm – Geographic Radius, Cycle through Networks

Implementation Guide:

- Network Directory
- Facility Directory
- Provider Directory

Call for Participation - Draft

Eric Heflin

Identifying Technical Teams and Infrastructure- Discuss Expectations

- <Capture Discussion During Meeting>

Information Exchange Scenarios and Discuss Test Data Strategy

- <Capture Discussion During Meeting>

HIMSS Presentations Materials – Booths, Marketing Communications

- <Capture Discussion During Meeting>

Next Steps

- <Capture Discussion During Meeting>

Additional Notes from December 8th In-Person Meeting

In-Person Meeting Objectives

Discussion

- Business side discussions – between now and HIMSS to support the pilot participants to operate together. Once the pilot is completed, are there additional items that need to be put into place?
- Do we need infrastructure to support the sharing – or are we doing it ourselves initially, and then growing it? Where does policy and governance fall in?
- Need a roadmap to content. Can we leverage activities underway in S&I Framework, Governance, etc.? Will need to look into whether it will be a low touch or high touch in terms of regulation?
 - Want to ensure that we can access any document
 - Next, agree on the set of filters
 - Then, as we learn more about other content, try to expand
- Additional Notes:
 - Put the right information into the resources hand and the the user/clinician can determine what is needed.
 - 2 ways – what we think the architecture is now; the other approach is to iterate.
 - Access control example – if you try to do an interoperability demonstration – may find that you need to look into this.
 - Does a centralized piece need to be developed like CommonWell – or does everyone have to set up a piece of infrastructure or build Carequality capability into each of the nodes?
 - Federal participation and rules strategy.
 - Cell carrier approach – where Verizon, AT&T, etc. offer a package of services that might drive one to purchase (but they are still able to talk to each other).
 - Not opposed to Healthway with a directory capability/all known directories.

Workgroup Focus Discussion

- In the specification/implementation guide: Should have 2 different onboarding, testing, validation sections in the specification – one as a software developer, the other as the implementer/node/network
- Differentiate between SLA – here's the SLA for a given node – rather than establishing timeframes; Need to work on the metadata that sets expectations on what we would like to receive and how to manage it
- How to bring organizations along that work in a more asynchronous mode?
- Query Workgroup Focus
 - Challenge of single subscribe / publish – example from Veterans for pharmacy info – messages are still being published post-mortem
 - Can still list in our roadmap – having some additional guidance for Direct might be something we put on the list as the backlog? Add in Direct and FHIR to the list for future considerations
 - Or do we look at Query/Retrieve; Direct Push; Publish/Subscribe? We are going to have FHIR and IHE – we are going to have 2 profiles – how do we create a migration path? **Initially IHE XCA/XCPD, then MHD (FHIR)**, the Edge Case (Direct for Query), and Pub/Sub
- Suggest that Exchange Protocols – we are going to address in this cycle vs. the bar – put this out to a vote. “technical protocols being targeted”, “use case being targeted”, and “security protocols”
- Need a safe harbor – confidentiality - organizations need to feel safe that the results are not going to be exposed.
- How to differentiate between “I am asking for documents” vs. “I am asking for data”?

FHIR Introduction & Discussion

- FHIR is anointed as the successor for HL7 v3 messaging as well as the CDA
- FHIR in a non-RESTful way can still be used – there is no requirement that you only use FHIR in a RESTful environment, but it helps to be consistent over time.
- FHIR has Core Team concepts and Auxiliary Team concepts. It enables the ability for other organizations to curate other auxiliary resources. Core Team will own them in absence of other “homes”.
 - Radiology is a good example – DICOM is managed by an international entity.
- Supports query, push, and pub/sub
- NIST is developing FHIR tooling right now
- MHD was based upon DSTU1 – will be revised to DSTU2 in 2015, unknown how much can be reused, but wanted to get some experience with FHIR.

Security Discussion

- Action Items
 - Survey for security questions related to security and access control – authentication, encryption, non-repudiation, and access control?
 - Will ask if consumer preferences should be conveyed as part of the request and should they be computable? What have you used to do this?
 - Plan to give a presentation on the topic and use it to launch the survey
 - Outline security considerations in Specification – “stub it out and will develop it in parallel”
- Notes from Discussion:
 - What are the requirements that need to be set – what does the node need to be onboarded to?
Target: If onboarded to Node A, then onboarded to Carequality
 - Can we have some security and privacy team members start to model out the technical framework for security?
 - Must think through security and consent as not all networks (e.g. SSA) are covered under HIPAA for data sharing.
 - Work with test data, not production. Can we start with a single CA or would we start with multiple CAs?
 - Which network do I trust? What’s the level of assurance with cross-certification?
 - Want 2 CAs, cross-certification with Federal Bridge; level of assurance; two FBC CAs can do these: Digicert & Entrust for certificate authority
 - Future – review the eHEX access control

Patient Matching

- Should we determine a matching set today?
 - Parameters – key area to pursue
 - Logic (might want to be quiet on this)
 - Policies – there is a technical aspect to different policies
 - Behaviors (errors, etc.) – key area to pursue
- There was a real fear to have inadvertent exposure – to where the exact matching is too strict.
- Participants – volunteers: Mariann checking with Commonwell, Surescripts (RLS & checking on HPD), EPIC/Kaiser, Hans working with Siemens on eHealth Exchange Party
- **Scope: XCA – minimum, XCPD, HPD and/or XCPD for RLS**
- Notes from Discussion
 - XPCD has certain matching items; Need to distinguish between XCPD & XCA
 - Use XCPD ITI-55 on the first node – to find the record (patient discovery) and then break up XCA into the document query and document retrieve
 - “Here are the elements we are going to send back and forth.” There are some where it is up to the participant as to whether they send them, but if they are sent, it shouldn’t break anything. Then there are the error conditions to provide when you are responding. Then, the algorithm is applied.
 - The data element list seems to be straightforward based upon the survey – always use these, -- start with the XCPD list and not make other requirements – this is for matching across networks, not within networks.
 - If under 18, VIP, or research patient, or marked as sensitive – it may not be appropriate to indicate there is a match.
 - Is the patient going to be there when you are doing the XCPD query? Might not do this in scheduled time.
 - Concerns about phishing in the past. Might have the ability to take advantage of local policies.
 - CommonWell does not need to use XCPD internally because it has central matching; one of the reasons they set up the centralized repository and have been considering XCPD between HIOs, is for inter-org.
 - CommonWell does a brokered XCA – don’t require each organization to know about the other organizations. Query is through central service. XCPD would be reasonable to consider per Peter B for inter-organization patient matching.

Message Orchestration

- Which one to use: Provider to Network?
- Where do we keep the Directory?
- Examples
 - San Diego Beacon – San Diego Health Connect – had to specify that the patients will know the organization as Sharp Healthcare.
 - Kaiser to Geisinger. Kaiser to IHC. Kaiser to CommonWell.
 - Don't need to start with a centralized UDI once you have a phone book
 - Kaiser is Epic, Geisinger is Epic and CCC – but CommonWell is infrastructure on the front end of the systems
- How do you get to the trusted list?
 - Currently, there is no service with a single trusted repository – don't want to do this until there is a single HPD.
 - If you're looking at nodes from a patient perspective, and the names the patients know – in the mergers, acquisitions, and typos-world – the data is not clean. There are organizations that manage this relationship data.
- Message Orchestration Diagrams From Meeting On Next 2 Slides

Pilot Participation

- Seem to have engagement/want participation from: Surescripts, CCC, Epic CareEverywhere, Hans is looking to talk to an eHEX
- What is the minimal set?
 - XCPD, XCA are the preferred. Even if XCA is the floor, we can do the XCA if we have configured a minimal set of IDs, and then HPD and UDI.
- Need to be able to show a full workflow – need to be able to show a real world use case of query and retrieve a document from a different network.
- Set up an ongoing Virtual Connectathon
 - Healthway is hosting a few for MHD and HPD. Kick off weekly webmeeting, screenshare, host a private collaboration space, keep tabs, etc. Basic use case outline.
 - Need some parties and materials to summarize the outline for the Virtual Connectathon.
- We should have a **call for participation** asking for at least one per member per category.
 - First 2 that connect in each category: 2 on eHEX, 1 IWG, 2 Surescripts, 2 Commonwell as RLS – working with PBMs to get data rights. Might be able to play an HPD role.
- Need marketing and technical contacts for each
- Keep Workgroup meetings at 2 hours; they might span out into separate project meetings.
- Version 1 specification publication and then real-world pilot.



carequality