Questions and Answers from I&HIE Roundtable on February 8, 2017: Carequality & The Health Data Sharing Tipping Point

1. If we are a lab vendor or health care organization, what steps would be needed to come on board with Carequality? Are there Business Associate Agreement's [BAA's] to be signed, contracts, what are the costs, etc…? Where should I go to get more information?
   Dave Cassel:
   a. Health care organizations would typically work through an EHR vendor, HIE/HIO, or service provider. The organizations who are currently Implementers can be found on our website, see specifically the section on Carequality Interoperability Framework Adopters.
   b. Vendors and other potential Implementers can contact admin@carequality.org to discuss options.
2. Have there been lab vendors that have signed onto Carequality? Specifically the large reference labs: Quest Diagnostics, LabCorp.
   Dave Cassel:
   a. We discussed this during the call; the simple answer is no, not yet.
3. Does the Carequality document transaction use the eHealth Exchange network/connect gateways or some other method?
   Dave Cassel:
   a. The specifications for Carequality's Query-Based Document Exchange use case are very similar to those used by the eHealth Exchange, and those who have implemented an eHealth Exchange gateway should reasonably be able to expect to connect for Carequality as well. The specifications are available in the Query-Based Document Exchange use case Implementation Guide.
4. Can you describe the revenue model for Carequality?
   a. This was discussed during the call.
5. For someone new to the concept of HIE's, how is the concern about exposure to personal health information (PHI) circumvented with HIPAA?
   Dave Cassel:
   a. HIPAA does not forbid the disclosure of PHI, but rather places guidelines around the circumstances in which this can occur, and what permissions are (or are not) needed from the patient under which circumstances. Carequality's "rules of the road" have HIPAA compliance as a fundamental tenet and the principles of good stewardship of patient data are interwoven throughout the governing policy requirements.
   Kristen Lynch:
   b. athenahealth interprets the exchange of clinical data for treatment purposes as facilitated by Carequality as covered under HIPAA. Our legal team has published documentation for our participating practices detailing our position on patient consent, which you can view online. We do of course encourage our clients to review the Carequality use case as it applies to their practice and state laws. We have built out workflows for practices to choose to withhold a patient's chart if the practice decides additional consent is necessary.

6. Can the panel speak to the challenges of gathering BOTH the provider data, pharmacy data and the payer claims into an HIE (as many have one or the other)? Few HIEs are working on all three, which is the most beneficial. Is it realistic to pull in all of them?
   Dave Cassel:
   a. Carequality is not an HIE, so I can't really comment.
7. Are vendors serving the Long Term Post-Acute Care segment of healthcare participating in Carequality? If so, who are they or where can I locate the participants online?
   Dave Cassel:
   a. One of our implementers is working with a number of LTPAC vendors, and we anticipate a number of LTPAC providers coming online for Carequality purposes this year. You can track live organizations on our web site.
8. Are the CDA documents actually stored in a central database or are they pulled real-time from participants local systems?
   Dave Cassel:
   a. This depends on the architecture of the participating systems. An HIE may have a central repository of documents, while an EHR vendor or service provider pulls them on-demand from individual instances. This architecture choice is generally transparent to other users of the Carequality Framework.

   Kristen Lynch:
   b. Exchange takes place real time between Carequality Implementers and the documents are not stored in a central database
9. Bringing on individual practices from the EHR level (eClinical Works, Nextgen, Athena, etc.) - does each individual practice need to sign on? Or can it be done at the EHR level for all of their clients without individual buy in from each individual practice?
   Dave Cassel:
   a. Since there is a need for the "rules of the road" to be legally binding on each participant, the legal relationship most vendors have with their clients will require some form of active acknowledgement/"opt in" from their clients. Some vendors may have terms of service that can be updated and apply generally to all clients, but even in this case, as noted by athenahealth, there is a need to ensure that individual clients have an understanding of the workflows and functionality involved in using the connectivity.

   Kristen Lynch:
   b. Each vendor's approach may vary, but, athena has adopted the Carequality framework as an implementer on behalf of our clients. We have incorporated the Carequality terms and conditions into our standard contractual language, which allows the addition of individual client's as Sub-Entities without the need for additional contractual arrangements with Carequality.
10. Kristen, can you comment on why your participation in Carequality does not automatically provide interoperability with all other (hundreds of) participants in Carequality (i.e., only Sutter Epic sites initially)?
    Kristen Lynch:
    a. athena's cloud-based technology allows us to enable Carequality functionality for our entire client base. However, we've learned that dedicating time to our clients change management process is imperative to driving the ultimate adoption of information exchange. In light of this, we also want to be very thoughtful about user workflows in order to ensure that data exchanged and accessed is meaningful and valuable for providers. We're rolling out Carequality by geography while we continuously improve

the workflows and data exchanged. Our goal is to roll out Carequality to our entire client base.

11. How do the Regional Health Information Organizations (RHIOs) fit into the Carequality model?
    Dave Cassel:
    a. RHIOs and other HIEs generally would be what we call Implementers of the Carequality Framework; they would sign on as one of the data sharing networks and programs that we enable to connect to others, and their members would gain access into all of the other participating systems (and vice versa).
12. How do you manage patient matching across diverse systems?
    Kristen Lynch:
    a. athena leverages a number of demographic fields to identify and match patients. If the set of demographic values provides the level of confidence required by our matching algorithm, the patient's record is automatically linked and available for data exchange. Additionally, athena has an internal Master Patient Index that allows us to identify anywhere a single patient exists across our entire network.
13. Vidant is an Epic EMR customer and have onboarded with CareQuality. We have several Athenahealth clinics in our area that have requested point-to-point interfaces with Vidant. Is Carequality available to athenahealth customers in Eastern NC?
    Dave Cassel:
    a. Broadly speaking, yes, Carequality is available. The clinics would need to work with athena to determine specific timing and any additional steps needed before they could proceed.

    Kristen Lynch:
    b. Yes, please let us know which athena clients Vidant is particularly interested in and we can work with them to enable them on Carequality as part of our open Beta.
14. Will analytics to support programs such as value-based care or population health be enhanced by Carequality? How?
    Dave Cassel:
    a. The simple answer is yes, because Carequality can provide access to information that can be used by analytics tools, and can enhance population health workflows. There is a great deal more to the picture, and it should be noted that Carequality, at least today and well into the medium-term future, will by no means provide all of the data needed for robust population health analytics.
15. What level of patient data are you exchanging? Admit/Discharge/Transfer data or also clinical details? How tightly does the data being exchanged integrate within your existing EMRs (e.g. Epic or Athenahealth), e.g. does it augment existing patient records?
    Dave Cassel:
    a. Data is exchanged today in the form of clinical documents. Efforts are proceeding to look at other forms of exchange, but clinical documents are exchanged right now. The contents of these documents will vary significantly depending on the system providing them, but often do contain discrete information on meds, problems, allergies, and immunizations that is available for parsing into the local record.

    Kristen Lynch:
    b. athena makes an ambulatory summary document available to Carequality Connections. This document contains all relevant demographic and clinical data in the patient's chart. Of the data elements exchanged, external systems are typically able to parse Problems, Allergies, Medications, and Immunizations into the local chart through data reconciliation.

16. How does Carequality address/deal with identifying patients across different systems, i.e. potential duplicating MRNs, etc.?
    a. This was answered during call, see also question #12
17. My experience is that while connectivity and frameworks are key, the real challenge to HIE entails the semantics and quality of the data being exchanged, and the workflows that create or consume it. How does Carequality address these areas?

    Dave Cassel:
    a. We are trying to work realistically with the industry to provide meaningful exchange opportunities right now, while also recognizing that there is ongoing work to be done. Our first priority was to establish the connectivity. We are now addressing what we anticipate will be the first set of more specific document content requirements, to address semantics and quality. We expect that we will be able to continue to raise the bar over time, although the pace at which that can be done remains to be seen.

    Kristen Lynch:
    b. athenahealth worked with other implementers to ensure providers have access to the data that meet their needs.
18. How is patient consent managed in the Carequality model?

    Dave Cassel:
    a. To provide a general and somewhat simplistic answer, patient consent requirements are largely at the discretion of the organization releasing the information. We are in the process of finalizing updates to our published Query-Based Document Exchange Implementation Guide that will provide a far more thorough answer, along with technical mechanisms for communicating access policy requirements and their fulfillment.
19. How does a patient information sharing system like this address the issue of "data ownership"? Specifically the thought that patients "own" their data, and perhaps should also have access to their own data through such networks?

    Dave Cassel:
    a. The Carequality Framework supports patient requests for information. There are several personal health record providers, directly serving patients, who have signed on to be Carequality implementers and bring patients directly into the exchange ecosystem.
20. Please explain the difference between Carequality and eHealth Exchange. Will Carequality replace eHealth Exchange?

    Dave Cassel:
    a. The eHealth Exchange is a data sharing network, and is one of those networks that Carequality aims to connect with others. It does not replace the eHealth Exchange, or any of its other constituent networks, which continue to provide additional value beyond Carequality to their respective communities of users.
21. Given the growing threat/breach landscape, can you speak to how individual organization onboarding and interoperability is addressed?

    Dave Cassel:
    a. Technical security is a strong consideration; see our Technical Trust Policy document.
22. How successful is interoperability when more than one EMR vendor works within one practice? How do you feel how it would affect Carequality?

    Dave Cassel:
    a. From Carequality's standpoint, connecting two systems that are deployed within one practice is not different from connecting two systems that are deployed in two separate

business entities. That said, note that Carequality does not aim to provide the internal workflow automation support (e.g. lab orders and results, scheduling, etc.) that a practice split between two systems would likely need.

Kristen Lynch:

b. athena has spent significant time working with clients in this situation. We feel that by leveraging services like Carequality and developing in-workflow access to external data, practices using multiple EMRs can be as successful as working with a single EMR vendor.

23. Can you please explain the architecture of Carequality interface with EHR?

Dave Cassel:

a. Please refer to our Query-Based Document Exchange Implementation Guide for technical specifications. (See link in question 3 answer above.)

Kristen Lynch:

b. Carequality provides the technical standards required, security certs, and manages the central directory of technical information needed to make a connection. The architecture uses the XCPD and XCA technical profiles as developed by IHE. Beyond the technical architecture, each vendor is able to autonomously define workflows and data access protocols within their respective EHRs.

24. Do the queries have to indicate which participant in the directory to go look for information or do they query all participants to see if they have any information on the patient?

Dave Cassel:

a. An individual query goes to a specific participant, although that participant could be a record location service, allowing for precise targeting of the organizations who have known records for the patient. It is not practical to query all individual participants.

Kristen Lynch:

b. This depends on your organizations internal architecture. athenahealth has developed our system to intelligently identify likely care locations where the patient may have been and automatically queries these care sites for available clinical documents.