Legal & Policy Advisory Group Meeting
July 16, 2013 2:30-4p

Name	Organization
Claudia Boldman	Information Technology Division
Kathleen Snyder	EOHHS Legal
David Szabo	Edwards Wildman Palmer LLP
Sarah Moore	Tufts Medical Center
Gillian A. Haney	MA Department of Public Health
Diane Stone	Stone and Heinhold Associates
Amanda Cassel-Kraft	MassHealth
Adam Tapply	Center for Health Information and Analysis
Support Staff	Massachusetts eHealth Collaborative
Micky Tripathi	Massachusetts eHealth Collaborative
Mark Belanger	Massachusetts eHealth Collaborative
Jennifer Monahan	Massachusetts eHealth Collaborative

Review of Materials and Discussion

Project Updates

- Mass HIway Phase 1- Transaction and Deployment Update (Slide 2)
    - The group reviewed the Phase 1 updates. Phase 1 operations are going live, while synonymously working through the design and deployment of Phase 2.
        - In June 106,331 transactions were exchanged.
        - To date, over 1,255,903 Phase 1 transactions have been transmitted through the Mass HIway.
        - All of the hard work from last year is now paying off in transaction volume and deployment!
    - There are currently three organizations in production: Beth Israel Deaconess Medical Center, Network Health and Massachusetts eHealth Collaborative. Four organizations are right behind, having complete successful test transactions: Holyoke Medical Center/Holyoke HIE, Tufts Medical Center, Beaumont Medical and Dr. Gregory Harris.
        - It was noted that the Department of Health and Human Services is also in production, receiving immunization data via the HIway.
    - On the near horizon, the Last Mile Implementation Grants are starting to drive movement. The grants involve approximately 51 sites. These sites will interact with the HIway to demonstrate a variety of use cases. They must also exchange data with another organization, which will create a web across the state demonstrating use. Interfacing with the HIway will take place over the next six months.

- Question: If BID, or any large organization, they are deploying, does that mean that is a connection to all of their physicians? Is it just the hospital? Is it possible to unpack that a little bit? Is it all or nothing with the providers?
    - Answer: It will vary a lot by organization, there is currently no set way of thinking about it right now. Different types of arrangements exist today; there are organizations that are willing to take the legal responsibility for all of their users, even those who are separate legal entities. For example at Holyoke and the Holyoke Health Information Exchange, Holyoke has said they will sign on behalf of the hospital and the practices that use their systems, even though they are separate legal entities. A single Participation Agreement will cover their behavior as well. As we think about how consent feeds into that, it may start to dovetail into that legal agreement.
- Question: Is this like the HISP to HISP discussion?
    - Answer: The problem is there is no set definition of HISP, some organization call themselves HISPS, even though they all may define themselves differently with coverage on Participation Agreements.
- Comment: EOHHS is currently working on an operational solution to this; the group plans to bounce it off the Advisory Group before finalizing.

- Phase 2 Overall Timeline (Slide 3)
    - The Phase 2 high level project schedule was reviewed.
        - Phase 2 requirements for gathering and validating information was added to the timeline with targeted completion at the end of July.
        - The Public Health nodes are either up or completing testing right now
    - The high level design for Phase 2 was discussed last month, the team is currently in the process of working through design details, and will provide a vetted design at the beginning of August.
        - Rebranded the Record Locator Service into the Relationship Listing Service (RLS).
    - Question: Are the Public Health items all Phase 1 or 2? Are those push or view?
        - Answer: They are push and they are in the phase 2 timeline because of the timing of the funding from CMS. There is no ability to view any of the public health registries right now.

Phase 2 Technical Design Under Consideration

- Legal-Policy Issue Framework (Slide 5). Over the next few meetings we would like to cover the following topics with the Advisory Group with the Technical and Policy controls today:
    - Technical and Policy Controls governing Phase 2 Functions. Slides 6 and 7 are a refresher.
    - RLS
        - Patient matching

        - Uses of RLS information
    - Consent (standardization, content, format and scope)
    - Comment: We may also want to include discussion of the "hierarchy of relationships."
- Phase 1 Services Today: User-to User Push (Slide 6).
    - The diagram illustrates the Phase 1 "push" services in use today. In principal there is also a provider directory getting accumulated over time as organizations sign on. If an organization does not know the address of a provider they need to send information to, they can look it up the provider address, and then obtain the necessary security credentials to encrypt the message before sending.
    - The provider directory could be wiped out of this illustration and it would be just like faxing and mailing. This method is making the process electronic, more secure and has a provider directory that facilitates unambiguous addressing.
    - Question: Is certificate number the public key?
        - Answer: Yes, it would be a public key. The HIway does not have access to private keys, except for providers that will be using webmail.
- Data Requestor Requests Patient Record- Data Holder Responds (Slide 7)
    - At the bottom left, the patient provides consent to send their demographic via Admit, Discharge and Transmit (ADT) feed to the HIway. The HIway would be collecting those in real time, and would process them in real time. The Initiate system creates the RLS; making available a listing of the patient, the institution, last event date and the number of events.
        - Should it include the Medical Record Number (MRN)?
    - Question: Have the matching criteria been established?
        - Answer: No, they are still under development at this point, but will be brought to the group for feedback.
    - Question**:** Is there any restriction on the requestor, for example is there any requirement that the patient I look for be registered at my institution?
        - Answer: We will get to this in the next slides.
    - If we look at wiping out the whole top of the diagram, RLS 2 and 4, the requestor and responder do not necessarily need the RLS; it is more of a convenience that the HIway provides. However, that would mean things are decentralized. But it does give the patient more flexibility with point to point consent.
    - Question: If not using the RLS, does that bypass any security controls?
        - Answer: No, the RLS is a convenience not a necessary part of infrastructure or security. There is no separate consent database. The fact that they are listed on the RLS means that they have given their consent to the data holding entity to do so. You can only get on the HIway by going through a validation process and have the correct certificate.
- **Policy and Technical Controls (Slide 8)**

- The table breaks out today's world on the HIway; the idea here is that for any type of constraint or any "rules of the road," there are either technical controls or policy controls. Where technical controls cannot be relied upon, policies will be put in place. For example, a provider cannot view a patient in the RLS if there is not an established relationship, the technology enforces this.
- Question: Have you encountered any technology controls that have unintended policy controls?
    - Answer: There are lots of things with patient safety which may have an unintended loss of flexibility. Something to watch out for, since we are "buying" a product.
- Today, the relationships between entities are automated within established trust relationships (e.g. "Magic buttons," CHAPS, SafeHealth etc)
    - It will be manual where trust relationships do not exist
    - Where automated, entity level authentication is the usual focus, while authorization is usually determined as part of a trust relationship. There are no possible technical controls for a manual process.
    - Policy controls on authorization and access will fill in the gaps left by the technology. Where manual it is only enforced through policies.
- Question: Are these trust relationships because they are nice people, or are these actual written agreements?
    - Answer: These are where formal agreements are in place.
- Comment: It may be more useful to distinguish between policy controls required by law, versus things that are best practice or more voluntary? Also, there are policy controls due to a lack of technical controls in the sense of a barrier or switch that prevents you from using the technology, you may need to implement some kind of user auditing; somewhat of a technical backstop.

- Policy and Technical Controls with MA HIway (Slide 9)
    - The table adds the Phase 2 policy and technical controls to consider
        - Disclosure will need to include the publishing of the patient/entity relationship on the RLS, viewing the relationships, requesting a patients record and providing the record
    - Question: Do patients know that these relationships exist; in other words do patients know that the "Magic Button" shares information with other "Magic Button" users?
        - Answer: Would you need to have one for the Magic Button? Could it be part of the consent to treat? The consent to use the HIE is different, you would not want to have people opt out of the HIE, but not understand that information is still being shared in a different form.
    - On the HIway the information published will be based on the permission given to the data holding entity. Information viewing will be based on the permission given to the requesting entity. Information provided by data-holding entities is based on the authorization represented by the requestor.

- On the technical side, there will be consent flags with the ADT message to establish the relationship. Viewing will be restricted to only the entitled entities that have a recorded relationship with a patient. Audit logs will be available.
    - There will be more authentication controls in Phase 2. The data holding entity makes the determination of whether or not a satisfactory level of assurance has been met in request. Trust will be based on entity authentication.
    - Need to consider the specialist situation; if there is a no established relationship how will the provider interact with the HIway. One policy decision made internally was to say that unfortunately this is the trade off, they may need to do this the old way; pick up the phone, fax etc. It seems like an appropriate balance to strike at this point.
- On the policy side, publishing the relationship to the RLS is facilitated through patient consent gathered by the data holding entity. If a patient does not give permission, the ADT message will not be sent to the RLS. Providing a record to another entity via the HIway will rely on the data holding entity validating authorization in order to send the information.
    - Currently, there is no way of requiring a response on the HIway. Some organizations could say "I am going to automate my responses to anyone on the HIway." Or some people might use a "white list" of trading partners.
- Question: The Magic Button is automated and provides a web based view and no one on the recipient end needs to do anything. Would a bulk of phase 2 work this way? Otherwise what is the difference between sending an email, and having someone respond - seems like it is just using Phase 1 technology?
    - Answer: The technical standards for request for query have not been established at the federal level.
    - Question: Shouldn't it be assumed that all organizations have signed a PA and have been vetted?
        - Answer: Yes, but that is not authorization for a particular patient. In terms of flexibility, some organizations may implement an automated response to everyone. It is up to each organization.

- Questions to the Advisory Group (slide 10)
    - Are there additional policy or technical controls that have been overlooked? Is the balance of policy and technical controls about right?
    - Question: Could there also be a technical requirement that a hospital Emergency Room establish a separate "ED node" so that you can differentiate where the message is coming from?
        - Answer: This is still being worked out. One option is to create a separate node. We do not have technical standards for query yet, but there might be a way from a technical prospective, to "bake in" an indicator to verify that the request came from the ED.

- Comment: If the patient is supposed to opt in under Chapter 118I, you could give a patient a permission form that says: Dr. A yes, Dr. B no, and any ED in the country; yes. This came up on the Provider call as well, the group plans to circle back on this issue with some ED provider input.

Next steps

- Key points and recommendations synthesized and provided back to Advisory Group for final comments
- Presentation materials and notes to be posted to EOHHS website
- Next Advisory Group Meeting – August 20th, 2:30-4:00 pm.
  - MMS Plymouth Conference Room, Or conference call – number to be updated in invitation
- HIT Council – August 5, 2013, 3:30-5:00 One Ashburton Place, 21st Floor

HIT Council meeting schedule, presentations, and minutes may be found at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/masshiway/hit-council-meetings.html