February 16, 2017

Donald Rucker, M.D.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St SW, Floor 7
Washington, DC 20201

Subject - Draft Trusted Exchange Framework and Common Agreement

Dear Dr. Rucker:

We are writing on behalf of the Joint Public Health Informatics Taskforce (JPHIT), a collaboration of nine national public health associations that represent a broad spectrum of public health informatics practice and policy in the United States of America, to comment on the Office of the National Coordinator’s (ONC) draft Trusted Exchange Framework and Common Agreement (TEFCA).

The Potential of the TEFCA for Public Health

There is great promise for public health in the concept of the TEFCA. In the nation’s developing electronic health infrastructure, public health agencies need to electronically connect with many healthcare sites to fulfill critical missions. Yet, frequently, public health is challenged to meet the trust, financial, and technical challenges of establishing and maintaining such connections. While HITECH and the broad EHR adoption it advanced has opened up great potential for electronic clinical care – public health connections in a positive way, it has also stretched public health’s ability to keep pace.

TEFCA offers public health agencies the promise of a “single on-ramp” to connect to this electronic health infrastructure. Theoretically, a public health organization could connect to one Health Information Network (HIN) and exchange data with those who are connected to other networks through a “network of networks” model. The TEFCA “single on-ramp” could help public health:

- eliminate the costs of connecting to many different networks;
- eliminate costly point-to-point data use negotiations and agreements;
- reduce individual system interfaces;
- allow public health the use of provider identity proofing and authentication provided by others; and
- allow public health the use of provider directories provided by others.
We strongly support these constructs of the TEFCA as a complement to, and not a replacement for, the hard-won progress of existing industry networks and services. Many of the existing networks and services have taken years to create. As ONC has indicated, the TEFCA “single on-ramp” should not be a constraint on new or old network services that can be provided but should prevent public health and others from being beholden to an array of sometimes redundant, disparate, and non-interoperable networks.

We commend ONC for including public health as a permitted purpose for health information exchange in the TEFCA and for the “flow down” of this permitted purpose from the Common Agreement, through the Qualified Health Information Networks (QHINs), through their Participants, and to the End Users. The public health permitted purpose could be highly significant in enabling data exchange and eliminating unsustainable point-to-point data use agreement needs.

We also strongly support the principles of exchange specified in Part “A” of the Trusted Exchange Framework, the vision for using data beyond those that are in EHRs, and that there should be no query charges for public health.

A Significant Obstacle to the TEFCA Potential
Events that initiate public health reporting begin in healthcare and other related health organizations. The overwhelming majority of public health transactions are, resultantly, of an “unsolicited push” nature. Public health cannot, as some have suggested, “move to query” for these core transactions because it does not even know that the events exist before a push transaction acts as notification. Without push transactions almost all of the TEFCA potential identified above will not be realized for public health.

Public health needs a core, required, push use case to take advantage of the TEFCA potential. TEFCA should express “flow down” requirements for the push use case in the Common Agreement, through the QHINs, through the Participants, and to the End Users.

ONC has stated that its charge from Congress in the 21st Century Cures act is “ensuring full network-to-network exchange of Electronic Health Information (EHI) through a trusted exchange framework and common agreement (TEFCA).” Including a required push use case is central to fully accomplishing network-to-network exchange and this important mission.

ONC has indicated that push was not included in this draft because “Direct is functioning very well.” But Direct and other existing push networks do not meet core TEFCA expectations and public health use cases. Push networks like Direct do not connect to other networks. Nor do these push networks eliminate the need for negotiated data use agreements among participants. Public health does not currently use Direct to a significant degree, but in situations where it does an additional Data Use Agreement (DUA) is necessary because public health is
not a permitted purpose in the DirectTrust agreement. There are, in fact, no permitted purposes in the DirectTrust agreement as it focuses more on the authentication and authorization aspects of trust.

There are some roles for query in support of public health. These roles are largely in areas that supplement, or add to, core push functions. What query opportunities exist can also bring complexities and challenges. One complexity lies in the data that are accessed. HIPAA, and at times State and Local statutes, limit the data that public health agencies can access. Under HIPAA’s “minimum necessary” provision, public health should only receive the data necessary to meet a specific purpose. It should be clarified in TEFCA and in the US Core Data for Interoperability (USCDI) that only necessary USCDI data should be shared for specific purposes.

There may be possibilities for public health in querying by condition or other patient attributes. But the identified TEFCA queries, queries by name and by patient panel, present fewer opportunities. Querying by patient name may be a useful adjunct in something like immunization forecasting. But even in this example, the data need to be as up-to-date as possible and will not likely be complete, accurately consolidated, or up-to-date when retrieved from an aggregated QHIN store. And while we support progress in advancing the promise of broadcast queries, the effort and challenges of reconciling data of all types from many different sources should not be underestimated.

**TEFCA Policy Issues**

All levels of government have specific responsibilities for public health. Many of the nation’s public health programs are carried out by government agencies whether they are about managing an emerging infectious disease outbreak, preventing illness and chronic diseases, or monitoring other health trends. Through TEFCA, ONC is delegating some responsibilities to a private sector Recognized Coordinating Entity (RCE). As this delegation is happening, it is important that ONC ensure that governmental public health responsibilities are still attended to and that core public health needs, like push reporting capabilities, are a required part of the minimum terms and conditions for trusted exchanged. Cooperative agreements can be weak management tools and it is also important that the governance and management of the RCE itself include public health representation.

There are other TEFCA policy issues that still need to be worked through. While we support the TEFCA concept for individuals to submit a “request for no data exchange” for many use cases, individuals cannot withdraw their health data from legally mandated public health reporting. TEFCA needs to develop a differentiation between optional and mandatory information exchange. We believe that the inclusion of a push use case with directed routing of data can be one way to help develop this differentiation.
• Individuals cannot “opt-out” of public health reporting that is mandated by State and Local laws
• A public health permitted purpose for health information exchange needs to clearly represent public health authorities to receive critical data when they are needed

We also believe that more work needs to be done to reconcile the TEFCA with jurisdiction-specific consent and data sharing rules. Communication about how the TEFCA concepts are reconciled with the very complicated legal and regulatory environment nationally will be an important part of TEFCA’s success.

**TEFCA Standards and Scale**
Public health has significant experience developing interoperability in environments like those that TEFCA describes. Participating systems and organizations are separated from each other by one or more intermediary and one or more network. The data exchange participants don’t know each other. And the scale of total connections defines a rigor for standards specification that is not usually present in point-to-point connections. With the caveats identified above, we also support the concept of the USCDI, but note that interoperability needs more than high-level data element identification to succeed in this TEFCA environment.

Public health uses implementation guidance for HL7 2.X messages and CDA documents to align connections between systems for data exchange of specific data in support of specific functions. These standards and specifications take time to develop and time to implement. Because many organizations cannot afford to change standards frequently, consideration should be given to both the timeframe allowed to implement new standards and the timeframe for eliminating the support of old standards. Overlapping support for both the new and the old standards is usually needed. Citing specific standards in regulation has been unwieldy. It is not clear that citing specific standards in a Common Agreement will be an agile approach either, but somehow additional standards need to be identified for other functions including public health.

• Public health needs additional message and document standards to be supported for the TEFCA
• A timeframe of twelve months is probably not adequate for identifying when everyone must support new standards. And even longer timeframes should be considered for when old standards should no longer be supported.

With limited resources, public health has endeavored to work with Standards Development Organizations (SDOs) to develop implementation guidance, messages, documents, testing infrastructure, and data element specifications to help drive interoperability at scale. With TEFCA and clinical care now working at comparable scale, public health needs more support
to work collaboratively with clinical care, to be an efficient electronic data trading partner, and be fully effective in nationwide interoperability. We support the use of pilot testing for key functions as well. We believe that public health should also be a participant in the pilot testing of relevant functions.

We applaud TEFCA’s progress in establishing provider directories that public health can rely upon for secure data exchange. We hope that ONC soon considers the needs for standards so that these directories can be used to also communicate out to providers as well.

Finally, we believe that the more awareness that can be generated of public health functions, the more understanding there will be of public health data and information technology needs. We recommend the definition of public health functions below to ONC and hope that the replacement of the existing TEFCA definitions will help broaden the understanding of public health needs: Committee for the Study of the Future of Public Health, The Future of Public Health: Summary & Recommendations. (1988) pg. 7 – 9\(^1\).

Thank you very much for the opportunity to comment on the Trusted Exchange Framework and Common Agreement. We look forward to working with ONC to fully realize the potential of this critical initiative.

Sincerely,

Marcus Cheatham, PhD  
JPHIT Co-Chair, NACCHO representative  

Susan Moran, MPH  
JPHIT Co-Chair, ASTHO Representative  

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• Charlie Ishikawa, JPHIT Executive Secretary

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