Trusted Exchange Framework Task Force

Transcript
February 26, 2018
Virtual Meeting

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

Hello, and welcome to the Trust Exchange Framework Task Force. This is now our third meeting. Thank you for being with us today. We will officially call the meeting to order, starting with the roll call. Do we have Denise Webb?

Denise Webb – Marshfield Clinic Healthy System – Co-Chair

Present.

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

Arien Malec?

Arien Malec – Change Healthcare – Co-Chair

I'm here.

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

Aaron Miri?

Aaron Miri -- Imprivata – HITAC Committee Member

Good afternoon.

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

John Kansky?

John Kansky – Indiana Health Information Exchange – HITAC Committee Member
I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sheryl Turney? No Sheryl? Carolyn Peterson?

Carolyn Petersen – Mayo Clinic Global Business Solutions – HITAC Committee Member
I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. Sasha TerMaat? Not yet. Steve Ready? No Steve. Cynthia Fisher? Cynthia? Anil Jain?

Anil Jain – IBM Watson – HITAC Committee Member
I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Kate Goodrich? No Kate. David McCallie?

David McCallie -- Cerner – Public Member
I'm here.

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

Mark Savage – UC San Francisco – Public Member
Hello? Here.

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

Noam Arzt – HLN Consulting – Public Member
I'm here.

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

Grace Terrell – Envision Genomics, Inc. – Public Member
Here.

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

Okay. So, we may circle back about halfway through, just to see if other members have joined. But at this point, I will turn it over to Arien Malec.

Steve Ready – Norton HealthCare – HITAC Committee Member

Hey, this is Steve Ready. I don't not know if you heard me when I got on. I am here.

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

I did not. Thank you, Steve.

Sheryl Turney – Anthem Blue Cross Blue Shield – HITAC Committee Member

And this is Sheryl Turney also.

Sasha TerMaat -- Epic – HITAC Committee Member

Sasha TerMatt.

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

And Sasha. Great. Anyone else on the phone that did not call? Okay. Thank you, guys.

Arien Malec – Change Healthcare – Co-Chair

This is Arien, and we're going to walk through the most exciting part of our overall charge. Actually, I think permitted uses and disclosures is the most exciting part of our overall charge. But, we are going to walk through the incredibly exciting set of definitions and requirements for qualified HINs. As a reminder, relating to the overall flow, we spent our last meeting on the RCE. Today will be on QHINs. This Friday will be on permitted uses and disclosures. Then, Monday, will be on privacy and security in the HINs special. Then we will go dark a little bit to write up until draft recommendations and spend a couple meetings reviewing draft recommendations, which lights us up for the HITAC meeting. We have a pretty heavy schedule ahead of us.

So, with regard to the qualified HIN, first of all, we need to establish whether it is a QIN, a QHIN, or a qualified health information network. The choice for the appropriate acronyms is incredibly important. But, here is a set of questions for which we want to get answers and perspectives. And I'm going to add to this based on the last meeting that we had relative to RCEs. I think the consensus, for the RECE discussion, was that we should refactor some of the relationships in the RCE and the qualified health information networks. So, maybe also ask the question about which of the roles and responsibilities for qualified HINs should be set in policy versus the ones that should be set via ongoing discussion amongst the qualified health information networks and the RCE.

Is the way that the qualified HIN's are defined meet the policy goals? And I define policy goals of achieving broadcast query, or achieving the ability for a provider or a patient to

discover the records for a patient regardless of chosen technology or the size of the provider organization. In discussion, I have heard a lot of appropriate concern about small and independent practice, and their ability to achieve these goals.

With regard to the capabilities for connectivity broker, is the chosen model sufficient to achieve the policy outcomes? With regard to transparency, including participation agreements, fees, and supporting the USCDI, do we have sufficient mechanisms to address qualified health information network transparency? There has been a lot of discussion that I am aware of, relative to fees, fee schedules, and whether the way that fees are defined improve, impede, or otherwise address sustainability for qualified health networks and innovation for qualified health information networks. And then, a catchall – what are the criteria we should consider and contemplate relative to qualified health information networks?

I'm going to pause and just look, from the group, to see if there are any high-priority – not detailed, but high-priority items that are not on this list that we should be discussing.

Noam Arzt – HLN Consulting – Public Member

This is Noam. I have just one comment that sort of bothers me about all of this. To some degree, we are putting the cart before the horse, and I just want to get that out there. We are talking about, in today's call, the definition of a qualified HIN, as you said, within the policy framework that the document presents. On Friday, we are going to actually talk about the acceptable uses – I'm sorry if I'm not using the right phrase.

Arien Malec – Change Healthcare – Co-Chair

Permitted purposes, yeah.

Noam Arzt – HLN Consulting – Public Member

Permitted purposes, and perhaps something about them – it's not clear to me if we're ever going to actually talk about use cases more specifically. But, I have a problem with the way the permitted purposes are presented, and with the basic functionality, particularly from a public health perspective, that this is only about broadcast query. So, if you are asking me to have the conversation today in the context of broadcast query, I do it under protest, because I do not accept that as the correct or complete functionality. So, it looks like you have accepted it as the frame within which we are going to comment and discuss this document.

Arien Malec – Change Healthcare – Co-Chair

Super useful feedback. I would ask you, when we talk about the proposed capabilities of a qualified health information network, that we assume for the purpose of this discussion, that the permitted purposes are what they are. And in particular, that public health is a priority use case. And, if you believe that the definition of a qualified health information network is insufficient, I would ask you to bring that up when we talk about the definition and the notions of a connectivity broker. Does that make sense?

Noam Arzt – HLN Consulting – Public Member

Yes. The issue is that broadcast query is what is insufficient.

Arien Malec – Change Healthcare – Co-Chair

Yep. Okay. I hear you. I see three hands up. David, Mark, and Sheryl. So, take it in that order.

David McCallie -- Cerner – Public Member

Okay, David. First, I propose we call it QHIN for the purposes of speeding our extremely limited time. Second, I am worried that we have way too little time for such a complicated and important topic. It is the essence of the draft, so I register mild protest that we are not going to get much of this covered in an hour, at least, based on how long it took us to discuss it internally.

But third, and less facetiously and more to the point, I agree with the notion that these are ill posed questions, because they are mixing technology and architecture with principles. So, the fundamental question is the wrong question to ask. Does the QHIN and support the goal of broadcast query? That shouldn't be a goal. The goal of QHIN should be something like making patient records accessible regardless of the point of care, as Arien started the conversation with. So, I'm going to answer my questions in that context, so it will get repetitive and boring, but I just would warn you up front.

Arien Malec – Change Healthcare – Co-Chair

David, I completely agree with you, I think you heard me silently rewrite the sentence on the fly.

David McCallie -- Cerner – Public Member

You did.

Arien Malec – Change Healthcare – Co-Chair

Support policy goals relating to access to data, regardless of size or setting. And then, look at the proposed architecture with regard to those policy goals. I think that is a useful frame.

David McCallie -- Cerner – Public Member

Yep.

Arien Malec – Change Healthcare – Co-Chair

Mark.

Mark Savage – UC San Francisco – Public Member

So, as important as all of this is, I also want to list out how we factor in patient generated data as an interoperability use case. I don't see much on that, but I think it is a functionality

that goes down broadcast query. I do not know where you want to weave that in, but I'm putting it out there.

Arien Malec – Change Healthcare – Co-Chair

So, Mark, maybe the way that I would think about that – maybe we can placeholder this discussion-- but the way that I would think about this is that a qualified health information network, a QHIN, should be somewhat content agnostic, somewhat respondent agnostic, and that the USCDI would be the place where PGHG, or other kinds of patient generated data, would reside.

But, you are raising the question about the patient as an actor, both as a source and as an active query with regard to the QHIN architecture. Am I framing that right?

Mark Savage – UC San Francisco – Public Member

You are. And, I am also making sure that we are thinking of information flowing in multiple directions.

Mark Savage – UC San Francisco – Public Member

Yep. Perfect.

Mark Savage – UC San Francisco – Public Member

Which is not clear from much of the language that we are seeing in the documents. So, that is why I'm raising it.

Arien Malec – Change Healthcare – Co-Chair

That is why I framed this as patient is an actor, both in terms of as a source and as an accessor, as a key policy goal the QHIN should be addressing. Alright. Sheryl.

Sheryl Turney – Anthem Blue Cross Blue Shield – HITAC Committee Member

Sheryl Turney. My point was, in addition to those questions here, I think we need to talk about authorizations and disclosures. Because, as you read it in the framework, it sounds as if the QHIN should be the holder and purveyor of authorizations and disclosures. And quite honestly, it may be a technical architecture where there is a patient portal provider. And, that would seem to make more sense, to be part of that component rather than a responsibility of the QHIN itself, unless what we are trying to say is that the QHIN able to transpose. And then I agree, but that is not really the way it is worded today.

Arien Malec – Change Healthcare – Co-Chair

Okay. Great considerations. And Carolyn.

Carolyn Petersen – Mayo Clinic Global Business Solutions – HITAC Committee Member

I just wanted to voice my support for the way you framed that, Arien, and the comments of the previous speaker in terms of the patient as an actor, information flowing in both directions, and the need for the ability to handle data coming from patients created by patients. Thanks.

Arien Malec – Change Healthcare – Co-Chair

Awesome. Thank you. So, let's make sure, as we are going through this, that we , number one, separate policy goals from architectural enablement. Number two, that we look at the needs of public health, and the needs of the patient as an actor, both as source and querier, with regard to those policy goals and the chosen enablement. And, that we look at authorizations and disclosures and make sure that we have factored the responsibilities for those two areas appropriately with regard to the policy approach and the enablement approach that we take with regard to QHINs. It seems like that covers the comments. I find it useful to frame up – are we vectoring in too deep, or should we come should we take more of a broader role?

So, again, I am going to reframe this. Let's note that, first of all, in the TEFCA draft, the way that ONC frames up a health information network is any organization that improves information flow, or facilitates information flow, among multiple parties. And then, ONC creates a term of art called a QHIN, which meets the definition of a health information network and does the following activities. And, as I said, with regard to these activities, we need to have a somewhat explicit acknowledgment that the goal of these obligations is to facilitate information exchange, meeting the needs of multiple provider types, including small and independent practice. I think we ought to add, relative to Noem, Mark, and Carolyn's points, that it also includes the patient, both as querier and as information source.

And so, with regard to those policy goals, the goal is to be able to locate and transmit electronic PHI between multiple persons and/or entities electronically, and have mechanisms placed to impose minimum core obligations and audit participant compliance. So basically, it would serve as a point of policy enforcement with regard to the legal and contractual obligations. It would control and utilize a connectivity broker service. A lot that the discussion we'll have will get into the definition of what a connectivity broker is, and whether the connectivity broker concept is sufficient to achieve the policy goals.

It would be participant neutral. And again, there has been a lot of discussion relating to what the definition of participant neutral is, and whether that is sufficient to achieve some of the transparency goals that a QHIN is supposed to achieve. And, it will exchange of data in practice in a live clinical environment. So, it would not just be a policy shop, or a technology shop, but actually facilitating information exchange.

I am going to punch the controls and utilize the connectivity broker service until the discussion of the connectivity broker. I want to look at the other components here, which are the policy goal of being able to locate and transmit EPHI between multiple persons and entities, have appropriate mechanisms in place to allow this to be legally enforceable, the definition of neutrality, and the definition of active exchange. And, I want to get comments on this particular definition.

I see that David has his hand up, and I'll call for other folks to put their hands up as well. There go the hands. We are going to do David, John Kansky, and Mark Savage. And anyone else wants to put their name in the queue, let me know. Go, David.

David McCallie -- Cerner – Public Member

Okay. So, I have a lot of comments for when we get into the details on the next slide of the connectivity broker. I will save them. But, I will make the high-level comment that I think the question is framed poorly. The question is really what are the policy goals of the QHIN, and are those the right policy goals. And I think that, for the most part, if you read between the lines, they probably are. But, couching it in the language of a particular architecture, like the query broadcast model, is where I think we are going to get into trouble. But, maybe the details of that could come up in the next discussion.

I wanted to ask a question on the participant neutral, and maybe someone from ONC could answer. Or, maybe I will just register it as a question. It wasn't clear to me whether this precluded a vendor from being a QHIN for their own customers. I think most people have interpreted it that way, but I was not sure if that was the express intent. And, is it possible to get a comment on that?

Arien Malec – Change Healthcare – Co-Chair

Hold on. Before we go there, David, I'm going to put your first comment as expressing the perspective that the TEFCA should be very explicit about the policy goals that a QHIN is enabled to achieve, and put a clear separation between those policy goals and the technical enablements. And I think, based on the discussion, I framed up one of the policy goals relating to provider use cases. I think Mark very helpfully framed up some policy goals relative to patient-based use cases, and I think Noem has framed up some policy goals with regard to public health that we probably should get to, and make sure that we are making good recommendations for how those policy goals are framed up.

Your second question, then, is if intent of a person of neutrality to preclude an EHR vendor, as an example, from being a QHIN on behalf of its CHR. I'd also do a silent framing of Question B, which is if the definition is sufficient to address the concerns. Maybe it would be useful to be explicit about what those concerns are from ONC. Is the definition sufficient to meet the concerns that this definition is seeking to address? Sorry, go ahead. Zoe, is that you?

Zoe Barber – Special Assistant, Principal Deputy National Coordinator for Health IT, ONC – U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT

Yeah, hi. this is Zoe from ONC. I would say that our intent here was to define a qualified HIN in a way that would preclude just a single vendor, or a single HIE, or any kind of single entity from being a qualified HIN on behalf of its own participants. So, we'll want to take into consideration any issues with conflict of interest. I think it would apply here. So, having just one single EHR vendor that is serving all participants, there would be a clear conflict of interest if they all rolled up to that single HER vendor. So, we are really looking for multiple organizations to come together to support multiple types of participants and end users.

Arien Malec – Change Healthcare – Co-Chair

Zoe, it occurs to me, with regard to the language and the policy goals – I think you have nicely articulated the policy goal. I'm going to frame this up and test for understanding. It seems like ONC has a concern that this market will turn into a bunch of technology vendors to seek to achieve information exchange on behalf of their own individual EHRs, and then we will get some level of market failure because that will not be sufficient to address the needs of other actors, such as small and independent physicians who may engage in activities that seek to benefit one particular segment of the market to the exclusion of others. Is that a fair framing in terms of the policy concerns that were driving in this definition?

Zoe Barber – Special Assistant, Principal Deputy National Coordinator for Health IT, ONC – U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT

Absolutely. That is exactly right. And then, on top of that, going back to the way the question is phrased, the intent is to have a small amount of qualified HINS. We believe that is necessary to support broadcast query at the scale of a national network. We're looking for a qualified HIN to an aggregate of data for their participants, and be a gateway. And so, we are trying to get to that limited number. But there is a question about whether that is even necessary. Is there another way that we can get to the scale that we are looking for without having such a limited number of connection points of the top?

Arien Malec – Change Healthcare – Co-Chair

Perfect. Nicely framed. It occurs to me that the way this is worded, there is a really trivial two-step that you could do, which is to form a not-for-profit organization that might, for example, be some of the provider organizations that use your technology, and have them run some of the technology on your behalf, that they procure through you. It just occurs to me that there are some ways of sidestepping this particular definition that might not meet the policy goals. That's just a personal comment. I am going to going on to John Kansky, Mark Savage, and then Sasha is in the queue as well.

John Kansky – Indiana Health Information Exchange – HITAC Committee Member

This is John, and my comment was participant neutral specific. While I raised my hand five minutes ago, I think the last five minutes has helped to somewhat make my point. My point is that there is tremendous market confusion over what the definition of participant neutral really means. And I have come to conclusion that there is no point in reading the words in the TEFCA. I have inferred what I have from hearing ONC speak to this a number of times. But that disconnect is not helpful.

So, ONC needs to clarify what they really mean in terms of QHIN requirements on participant neutral. The problem that creates is that it is difficult to discuss or think about whether the QHIN requirements are framed correctly if you are not sure what that participant neutral requirement really means. And then, finally, just a comment on what Zoe said. I think you addressed it. There is a presumption on ONC's part that they want a small number of QHINs, but they are not really sure. And I generally think that specifying architecture with policy is a bad idea. So, we should try to avoid that.

Arien Malec – Change Healthcare – Co-Chair

Okay. So, John, I'm hearing – I think I have heard this from a number of people, that it would be helpful for ONC to be explicit about the policy goals with regard to participant neutrality separate from the actual enablement. And then, I am also hearing you register a concern that the policy goal of having a small number of QHINs may not be an appropriate policy goal. But, to be fair, if that is the policy goal, then let's make sure that we test the enablement relative to that policy goal. Mark, Sasha, and then David wants to get back in.

Mark Savage – UC San Francisco – Public Member

So, on the overall requirements, I am looking for something around usability. Cures talks about it; the interoperability roadmap talks about it – words like "without special effort" and things like that. It goes beyond just locate and transmit. So, my concern with usability is not just around QHINs. I think the draft, as a whole, could use more discussion about that. One place that the language in the draft does help is about the APIs. So, it is a place where we're recognizing that they need to do something with usability as well. They do have some capacity to do that around APIs. But again, the issue of usability.

Arien Malec – Change Healthcare – Co-Chair

Quick follow-up. Are you looking for the QHIN to define the actual user interface, or are you looking for the QHIN to have a role to improve the "without special effort" implementation?

Mark Savage – UC San Francisco – Public Member

Since we are focusing more on policy than architecture, I am looking more at the broad goals here. I think interface can be one place. I think APIs can be another. But, I'm just noting that in other places we have said just access and transmitting is not enough. You have to make sure that the information is useful and usable.

Arien Malec – Change Healthcare – Co-Chair

Gotcha. Okay. Thank you. Sasha.

Sasha TerMaat -- Epic – HITAC Committee Member

Hi, folks. This is Sasha. I agree with a lot of the conversation about participant neutral and the comments so far. It seems like, if we specify the outcome more clearly, we might be able to debate the best approach. My theory is that, to some extent, the goal of the overall connection to all of the QHINs together should be neutral and accessible to all of these parties. But it seems possible that that neutrality across the entire network of networks could be achieved while also enabling certain QHINs to focus on particular types of users. And, that might be EHR vendors, that might be particular QHINs that just focus on a certain other area. So, I think if we clarify the concerns of overall accessibility and access across the networks, we might be better to better evaluate if there are policies that need to affect a particular QHIN, or if we are really concerned about a policy directive that should apply across all of the QHINs.

Arien Malec – Change Healthcare – Co-Chair

Gotcha. So, you are looking for that policy goal to be attached to the operations of QHINs in practice, even if there may be particular QHINs that may carve out one particular segment of the market. I do not think I am speaking out of school to say that at least -- I should not say that this is aimed at one particular actor, because I think there are a number of EHR vendors that have sought to achieve information exchange among their own particular EHR vendor. As I quasi alluded to, I think people do not recognize that Care Everywhere is not actually an operation of Epic. It is an operation for a not-for-profit of provider organizations that do governance for technology that is built into Epic.

But, I thought it would be appropriate to comment from the perspective of a large technology vendor that serves to broad swath the market. What is the best way to achieve the policy goal of making sure that QHIN operations are available to the broadest swath of the market? You both have a fair amount of experience doing a large amount of exchange in practice. And then, I think people also note that that exchange tends to benefit the folks who use a particular technology asset. Again, I am not calling out Epic as a particular example. There are a large number of organizations that have sought to achieve that. Maybe Epic just gets blamed because they do better than anybody else. But, I would love your comments on that particular.

Sasha TerMaat -- Epic – HITAC Committee Member

I think as one portion, I did not actually understand that the intent of this provision was to enable accessibility to small providers. So, I guess from an editing perspective, I do not think that that intent is clear in this provision. I don't know that I think that this is achieving that, if that was one of the primary intents. I talk to Epic users, and they tell me that some of the rapid onboarding that they have been able to do through Care Everywhere to Care Equality has been streamlined. When they get excited about the use cases and opportunities of the Trusted Exchange Framework, they would like to see a similar type of rapid onboarding. To me, that seems advantageous to the whole network if there are existing networks that are able to rapidly onboard, and then be exchanging and accessible to all the other participants.

I am not sure that I see that the stuff in the middle that happens practically, of creating other networks, onboarding with them, and then connecting to the Trust Exchange Framework has an end benefit of advantage to the Trusted Exchange Framework, at the endpoint.

Arien Malec – Change Healthcare – Co-Chair

Super helpful. So, what I am hearing you say is there is a lot of benefit for building streamlined onboarding into the technology that you support, or into technology that providers use. And that benefit helps to address some of the things that Mark was looking to call out relative to "without special effort." Number three, I think you are looking to be more explicit around the policy goals and objectives with regard to participant neutrality.

Sasha TerMaat -- Epic – HITAC Committee Member

Yeah. I think we could think of a lot of different opportunities here. If throw out some other examples, since you called me out. But, if Apple decided to be a QHIN for patients, or if Amazon Prime in the future offered some sort of Interoperability Prime, there might be a whole variety of different services that might focus on specifically patient segments of the market or specifically other portions. And, it would still be advantageous to have them be able to connect if they otherwise met the expectations of a QHIN. And if we are worried that in other requirements of a QHIN are not sufficiently transparent or neutral, then we should specify that in those details.

Arien Malec – Change Healthcare – Co-Chair

Super helpful. Thank you for that comment. David, and then we will go back to the connectivity broker obligations themselves.

David McCallie -- Cerner – Public Member

I appreciate Zoe's clarification on the intent of that somewhat cryptic language. My pushback would be, I think, in line with what Sasha just said, and others. It's that if a QHIN has certain obligations, legal and moral, as having signed a common agreement, that should be what they are judged by, and not who they have aggregated and agreed to expose the data. So, there is a requirement that the QHIN must respond to a query about a given patient and produce all the data that it has about that patient, using then current USCDI, as long as it is compatible with permitted purposes.

All that language, put a period at the end of it, and say that's what a QHIN should be. Then there's an independent question about auditing and transparency of QHINs that I do not think it is automatically solved just by saying the QHIN has to be a third party. They still have to do audit and they still have to be transparent. So, decouple those two, define how your audit is supposed to work and what's transparency defined in terms of, and then define what a QHIN's behavior has to be. They must respond, and let it be at that. I do not think you need to go further.

Arien Malec – Change Healthcare – Co-Chair

I apologize to the rest of the group, and we will give people opportunity to jump back in. But, I'm going to pose a question back to Sasha and David. I can imagine that one of ONC's policy issues, when they thought about doing this in practice, is that if the QHIN rules are not defined well enough, you might have a network effects model that actually works against broad scale connectivity. What I mean by that is, when we see networks form and aggregate, they often form around the largest participant networks. They serve as natural attractors, but if there is no forcing function to aggregate beyond those large organizations, you may end up with a set of information exchanges that work in practice for a particular subtype, or a particular subgroup of, for example, provider organizations or users of a particular EHR vendor.

And again, not due to intent, information blocking, or malicious behavior, but just as a side effect of network effects, they up being not scalable to the 20 percent of the market that is not covered by the big five EHR vendors. And I just wanted to pose that question. Is that a useful policy concern to articulate? And, and maybe pose back, do you understand why ONC

might have chosen to put these requirements into practice. Are there alternatives to these requirements that might achieve the same policy goal? I will start with Sasha.

David McCallie -- Cerner – Public Member

Good.

Sasha TerMaat -- Epic – HITAC Committee Member

I was going to let David go first. So, if we have an overall policy goal of affirmative action for small participant in the Trusted Exchange Framework, we should articulate that as an overall policy goal, and then discuss the best way to implement it from a policy perspective. Maybe there are expectations for the RCE to enable that. Maybe there are provisions for specific QHINs that advantage having certain types of participants that we think are undeserved in the current model. But I am not sure that I see how the proposed participant neutral language achieves that.

Arien Malec – Change Healthcare – Co-Chair

Okay. Very fair. Number one, let's articulate the policy goals. Number two, if that is a policy goal, test that policy goal relative to the language. David? And then, I see John Kansky has his hand up.

David McCallie -- Cerner – Public Member

I agree with the points that Sasha made. Let me add a couple of other clarifications on what I said before. I fully expect that there will be multiparticipant QHINs. In fact, it would not surprise me if that is the only thing that makes business sense in the long run. I just do not think that is a requirement that the QHIN has to be multiparty to meet the obligations of the QHIN on the network. I think a single entity could fully meet the obligations of the common agreement. And I do not see an automatic conflict there. If there is a conflict, it should be surfaced by whatever the rules are around transparency and audit.

So, by no means am I suggesting that a large vendor could become its own QHIN and refuse to talk to the rest of the world. That would absolutely be inconsistent with the common agreement. If you are a QHIN, and have earned the designation as such, you would be obligated to respond to any external query about any patient that was being queried that is inside your vendor network. Absolute, no question, you must respond – as must every other QHIN. That is the rules for QHINs.

But, it does not really matter what you have inside to decide how to do that. If you have a population health service in place that already has all that data ready to go, and it has an MPI and a record locator service that does not happen to follow the particular IHE protocols that will come up on the next slide, so be it. You're responding of the QHIN, and that is what you should be held accountable for.

I'll add one footnote. I do not think that every query automatically needs to be broadcast, because I think many physicians would be perfectly well served by directed queries when they know exactly what they are trying to get and they know where to get it from. That does not need to be spread to the rest of the network. But, any participant who wants to do a

broadcast query absolutely should be allowed to. And that would be, again, built into the definition of what it takes to qualify the QHIN. You must broadcast if you are requested to do so by a participant or by an individual. And you must respond to the outside world, no matter what. Again, assuming permitted purposes and all those caveats about legal transactions.

Arien Malec – Change Healthcare – Co-Chair

Yeah. I just want to point out, though, the issue that I was framing was a slightly different issue, which is that, if you do not have multiparticipant networks, you could end up with 80% of the market being served, but 2o% not being addressed. But, I'm not going to push that point anymore. I'm going to go to John Kansky, and we are going to go to the very fun definition of a connectivity broker service.

John Kansky – Indiana Health Information Exchange – HITAC Committee Member

I will try to be quick, Arien. Actually, it's the question you posed as to whether -- trying to make sure that that 20% of the market, whether it be consumers or small providers, whether that is a good policy goal. I think that it is and, in the context that 21st Century Cures is requiring ONC to publish a TEFCA., I wanted to suggest it might be a much more direct way to get there, to focus on the obstacles and removing them, that have prevented that from happening, whether it's market failure or otherwise, rather than trying to specify an entire design of and an interoperability system for the nation that we believe will address that. I just think there is a simpler way.

Arien Malec – Change Healthcare – Co-Chair

Thank you. Very helpful. Okay, let's go on to the next slide, which says all of section 3.1. So, maybe I could turn it over to Zoe in terms of the definition of connectivity broker capabilities, and then we will surface that discussion back to the group.

Zoe Barber – Special Assistant, Principal Deputy National Coordinator for Health IT, ONC – U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT

Yes, there is a lot of language in 3.1. I thought it would be easier for people to reference their document. And so, looking at the general workflow of the qualified HIN, that they would receive a query from their participants or end users with whatever internal technical specifications or policies that they have specified. Then, the QHIN would send out that query to all of the other QHINs using the specified standards in Part B.

The receiving QHINs would then query all of their participants and end users, again using their internal structure. They would send a message back to the initiating qualified HIN, saying whether or not they have information. The initiating qualified HIN would then ask the responding QHINs that, if they did have information, to send that. The responding QHINs would receive all of the data from their participants and end users. They would combine it into one transaction, send it back to the initiating QHIN, who would then send that information back down to their participants and end users. So, that general structure and workflow.

Arien Malec – Change Healthcare – Co-Chair

Thank you for the summary, and sorry to put you on the spot. So, relative to public comment, we have about 15 minutes left. We also want to get to fees. Relative to other aspects to achieve transparency, and then also the definition of fees, in particular the definition of a reasonable allowable cost, the uniformity of fee schedules, the definition of reasonable and nondiscriminatory criteria for addressing pricing models, and then the notion that TPO can recover attributable cost but not individual access public health and benefits determination use cases. As well as the notion that QHINs may not oppose any royalty revenue share or any other fees on use of EHI once it's accessed.

So, in general I would note this fee schedule notion as seeking to achieve common carrier requirements for QHINs regardless of access model, and in some cases, above common carrier requirements with respect to individual access, public health, and benefits determination. We have a lot to discuss in what is effectively is 10 minutes. And, we have a couple of hands up already. So, this is really a call for discussion relative to the definition of a broker, and also relative to fee schedules and fee discussion. We have David, Noem, and Sasha in the queue. We'll go to David first. David knows the rule here, which is always put your hand up first.

David McCallie -- Cerner – Public Member

I have done enough of these. I have a little macro. So, on the broker stuff, I think the generic comment I have is that the functional behaviors here relatively make sense. The specific details about all of the architecture and standards probably do not. I think that should be left to the RCE to figure out amongst the stakeholders. For example, it references fire standards for population health. Those standards would be a complete mismatch, if they continue in the direction they are currently headed, for a query broker model because they require asynchronous fulfillment. Direct peer-to-peer asynchronous fulfilment wouldn't make sense in the QHIN model as it is currently architected here. So, I say stay away from the architecture. Let the RCE work with the stakeholders to figure out how the QHINs work. Just specify what the behavior has to be. And then on the fee question --

Arien Malec – Change Healthcare – Co-Chair

Sorry, David. In terms of specifying the behavior, at what level do you think the behavior should be appropriately specified?

David McCallie -- Cerner – Public Member

I think, for the core use case of patient treatment, what make sense to me is what I said a little bit earlier. Any QHIN would be obligated to respond to an outside request for all it knows about a particular patient, using functionality that is very similar to XCPD and XCA, and it might actually be XCEP and XCA since those are well understood technologies. And then, on the other direction, any of their internal participants or users who wish to request a complete query, a full federated query, the QHIN would be obligated to broadcast that to all the other QHINs, assemble the results, and deliver them back. So, it is mandatory response, optional query out, depending upon the need of the user.

Arien Malec – Change Healthcare – Co-Chair

Okay. I am sorry. Go ahead with the fees.

David McCallie -- Cerner – Public Member

That would be the summary. I really struggle with fees. I wish I could be as dogmatic as I sound on all these other things. I worry that the only thing that will make sense in the long run for QHIN-to-QHIN fees, is either price fixing by setting a price and saying the RCE will approve a certain price that we think is adequate to cover the cost of being a QHIN, or zero. Because, otherwise a QHIN is going to aggregate valuable patient information behind its walls and then be able to charge whatever they want for access to it, because you could pretty much drive any size truck through the loopholes of attributable costs. So, I am really concerned about the fee model. I wish I had a better solution.

Arien Malec – Change Healthcare – Co-Chair

Just as an editorial comment, a chair's prerogative, I think people who followed my Twitter account, to the extent that you've been able to follow anything that I do on Twitter, know that I have a weird overlap concern between common carrier requirements and then the definition of 21st Century Cure with regard to provider obligations and information blocking. My summary would be, of 21st Century Cures intends for all providers to respond for all permitted purposes, common carrier requirements might well make a lot of sense. But if 21st Century Cures intends that some permitted purposes require common carrier requirements, establishing common carrier requirements for all permitted purposes could end up driving strange market behavior. And, I think people have noted the ability to create a pseudo QHIN that does nothing, or maybe has one or two participants to get around the active participant piece. But then, it's able to freeload on everyone else's network. But, that is my editorial comment. I am going to go to Noem.

Noam Arzt – HLN Consulting – Public Member

The description here of a connectivity broker service is one thing. Again, I object to the assumption that this is all that a QHIN needs to do in order to satisfy the uses that have been defined, particularly the public health permitted use. A connectivity broker service simply does not help that.

Arien Malec – Change Healthcare – Co-Chair

Could you provide more specificity in terms of what public health use case would not get addressed through a connectivity broker service? Or, rather than talking about a connectivity broker service, let's describe it in functional terms. Let's assume the functional term is requiring being able to query for a patient and, in some cases, a population and get back all of the information known nationally about that patient through a set of owned and federated queries to other QHINs. Which public health use cases would not get addressed through that definition?

Noam Arzt – HLN Consulting – Public Member

Just about all of them. Public health is, by and large, and almost completely about pushing necessary and required data stipulated by state, local, and tribal law and policy, from EHR systems to public health. Whether it is immunization reporting, electronic lab reporting, electronic case reporting, cancer report -- all of them. It is not about any one query for anything, by and large. There are some exceptions, but by and large.

Arien Malec – Change Healthcare – Co-Chair

Thank you for that. That is what I thought you were going to say, and my comment in the HITAC to ONC is that when you actually look at the policy goals for a QHIN, they are aimed at that particular goal. And they step over a number of other goals that are served by, for example, directed exchange, either through director or for pushed public health messages, reportable labs, and the like. And it's not because they do not think they are important, but because ONC believes they are well served and, as an editorial comment again, I think some of the language around one-stop shopping or single on-ramp is actually not true in practice because it's single on-ramp for a particular set of functional needs, but not a single on-ramp for other functional needs that may well get served through other networks. And I think it is important, Noem, to your point, that we be clear about what it is the single on-ramp is intended to do and set appropriate expectations relative to things that it is not going to do.

Noam Arzt – HLN Consulting – Public Member

And notice I did not reply to you in any technology-based answer. This is not about direct or any particular technology. It is about the concept of push transactions supported by a national network.

Arien Malec – Change Healthcare – Co-Chair

Agreed. And I used the word directed exchange rather than direct intentionally as well. Hey, Sasha. Let's go to you.

Sasha TerMaat -- Epic – HITAC Committee Member

Thanks. So, I agree with David's point about leaving the broker architecture question to later definition with some of the other standards. In fact, I would push that we specify the expectations of a QHIN without even getting as specific as to say it had to be accomplished using a broker. I think, if there are networks that could accomplish the same outcome without a broker, that is something we would want to be open to as an innovation.

Regarding the fees, I struggle with that one too. The part I worry about is that I would like for it to be sustainable, to have an incentive, to use resources wisely, and to not cost shift. So, when you develop a large database, you have a lot of incentive to make sure that queries on your database are efficient and perform in a speedy fashion so that your users are happy. And, when we create a large network, we are going to -- for usability purposes mentioned earlier -- similarly want those queries to be speedy and efficient for the users.

And, to some extent, the individual folks making those queries do not have any incentives to do that because they are not necessarily sharing in the cost of the architecture and the

network in the same way. So, a programmer who puts a lot of time and attention into making a wise query at a very specific frequency, to very specific recipients maybe has the same cost as someone who writes a stupid loop and hits the whole system up in a broadcast query every minute. And it really taxes the architecture without an incentive to not do that, or a cost sharing that makes that person pay more than the person who put a little more time and thoughtfulness into it.

Arien Malec – Change Healthcare – Co-Chair

Thank you for that. Mark, for one minute – apologies. And then, we are going to go to public comment.

Mark Savage – UC San Francisco – Public Member

On point on the price line on transparency -- probably implied, but the API should be open and published for all the reasons we have already talked about for the past two to three years.

Arien Malec – Change Healthcare – Co-Chair

Perfect. Lauren, let's go to public comment.

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

Thank you, Arien. Operator, can you please open the line for public comment?

Operator

Yes. Thank you. If you would like to make a public comment, please press star-one on your telephone keypad, and a confirmation tone will indicate your line's in the question queue. You may press star-two if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

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

Thank you. And, just as a reminder, we ask public commenters to limit themselves to three minutes. Operator, do we have any comments in the queue?

Operator

No comments at this time.

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

Okay. If there are no comments in the queue, I will turn it back over to Arien for the last five minutes.

Arien Malec – Change Healthcare – Co-Chair

Great. First of all, I just want to acknowledge we went through a lot of content very quickly, and I would encourage task force members, if they have got thoughts that they weren't able to express – I see a lot of good stuff going on the chat. I think we're going to make sure that we aggregate the chat comments. But, I also encourage people, if they have more thoughtful comments that they were not able to get through in this task force meeting, that we get that out in the open. I would also say that, if this task force feels like we have a lot more to discuss than we were able to get done, notwithstanding some of the awkward timing of HINS, we can find a place to have more time. So, if there are any particular topics that you feel like were under addressed, let us know. And, given that, I will do another call for comments for the next four minutes, for folks who want to address more topics.

Denise Webb – Marshfield Clinic Healthy System – Co-Chair

Arien, we might need a minute or so to talk about what the plan for the meetings are.

Arien Malec – Change Healthcare – Co-Chair

Yeah, thank you for that. That is why it is good to have a co-chair. Zoe and Lauren, could we maybe go to the next slide, talking about our next steps. All right, just an acknowledgment that our next meeting on Friday goes to the not-at-all-hard-to-discuss and not-at-all-controversial topic of permitted uses and disclosures. So, I expect that one to be a fairly fun-filled meeting as well. And then, we go to privacy and security, which is also a very easy topic. And then we start going through recommendations. We really have only two meetings to review draft recommendations. I am open, at this point, if we feel like we have not gotten through enough, to contemplate doing three meetings that week. We just are under the gun relative to our ability present full recommendations to the committee on the 21st. And, I see Carolyn has her hand up.

Carolyn Petersen – Mayo Clinic Global Business Solutions – HITAC Committee Member

I just had a point relative to Slide 8, which was the one about other business criteria and such. We did not get to that. There are two things I want to put on the table with regards to the QHIN eligibility. First, a demonstrated ability to accept and transmit patient generated health data. That could be from things like wearable devices, in-home sensors, patient reported outcome measures, mobile apps -- these sorts of things that patients are using. And, just in terms of general PGHD, there is a real concern among providers about how to accept it, handle it, and what to do with PGHD. I think, in terms of patients getting value, we really need to be working with groups that have experience in that area.

Secondly, also some demonstrated experience working with patients or consumers in some kind of customer service function, whether that be healthcare, financial, or some other industry that has a significant amount of customer service. We've been talking a lot about the tech side requirements of things, but for the patient consumer users, it is really going to be about customer service more than tech. So, we need to capture that. Thank you.

Arien Malec – Change Healthcare – Co-Chair

Alright, with one minute left, I think we should adjourn.

Unidentified Speaker

Can I pile on to what Carolyn said, to say that expertise around the table also helps when we talk about developing new use cases, which is something for QHINs and RCE to be thinking about.

Denise Webb – Marshfield Clinic Healthy System – Co-Chair

I think I heard Zoe try to jump in.

Zoe Barber – Special Assistant, Principal Deputy National Coordinator for Health IT, ONC – U.S. Department of Health and Human Services, Office of the National Coordinator for Health IT

Yeah, sorry. Before we adjourn, my computer froze a little bit, so maybe I'm not seeing it. If we could just go to the homework slide, just to make sure we review what people should be looking at for the next meeting on Friday.

Arien Malec – Change Healthcare – Co-Chair

Thank you. Yep.

Denise Webb – Marshfield Clinic Healthy System – Co-Chair

Zoe will get out some slides. Or, actually, the team will beforehand -- with questions.

Arien Malec – Change Healthcare – Co-Chair

Yeah. And, this is in a slide deck that we sent out to you. So, please do your homework. Read your 21st Century Cures and understand the permitted uses and disclosures for the next meeting. Thanks for such an engaged task force. We have a lot to do and we churned through a whole lot of meaty topics today very efficiently. Thanks, all.

Denise Webb – Marshfield Clinic Healthy System – Co-Chair

Thank you.