Trusted Exchange Framework Task Force

Transcript
March 19, 2018
Virtual Meeting

Operator
Thank you. All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Hello, everyone, and welcome to the Trusted Exchange Framework Taskforce. We'll call the meeting to order, starting with roll call. Do we have Denise Webb?

Denise Webb – Marshfield Clinic Health 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
Carolyn Petersen?

Carolyn Peterson – 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
Aaron Miri?

Aaron Miri – Imprivata – HITAC Committee Member
Here.

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? Do we have Sheryl? We'll circle back.

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

Sasha TerMaat – Epic – HITAC Committee Member
Present.

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

Steve Ready – Norton Healthcare – HITAC Committee Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Cynthia Fisher? No Cynthia yet? Anil Jain? No Anil? Kate Goodrich? No Kate. Andy **Truscott**?

Andy Truscott
Here.

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

David McCallie – Cerner – Public Member
Here.

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

Mark Savage – UC San Francisco – Public Member
Here, thanks.

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
I'm here, but in a tornado and hail warning, so I will leave in a little bit and dial back in once I've come to a better place.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yes, please be safe. Thank you, Grace.

Arien Malec – Change Healthcare – Co-Chair
Be safe, yeah.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, Denise and Aren, I'll turn it over to you.

Arien Malec – Change Healthcare – Co-Chair
Cool.

Denise Webb – Marshfield Clinic Health System – Co-Chair
All right.

Arien Malec – Change Healthcare – Co-Chair
Should we go to the last spot that we were in, which . . .

Denise Webb – Marshfield Clinic Health System – Co-Chair
I can tell you where we were. It was right after individual access, I believe. And that was on, let's see here, page 12. Yeah. And I think we're on the recommendation about whether ONC should require individual access for treatment permitted uses?

Arien Malec – Change Healthcare – Co-Chair
And so the basic point here was that the ability -- the amount of production use and production testing for this use case allows them to be scaled more broadly, and that other uses and disclosures require broader scale testing.

Denise Webb – Marshfield Clinic Health System – Co-Chair
I don't see hands up. So, everyone's good with that?

David McCallie – Cerner – Public Member
This is David. I'll raise my hand and comment at the same time. There are a couple of places, Arien, where I think it's probably worthwhile mentioning that the USCDI needs to be kept in sync with the use cases.

Arien Malec – Change Healthcare – Co-Chair
We do that with SSA. Are there other cases that payment, public health payment --

David McCallie – Cerner – Public Member
Payment and public health both. It's just as a general principle. It's overarching. Some of the permitted purposes are not in sync with the current USCDI document, so.

Arien Malec – Change Healthcare – Co-Chair
I'm gonna make a better effort time to write in a way that is not equivalent to a one-way hash. So, the USCDI data standards need to be harmonized. Maybe the best statement here is that it's really designed for individual access and for treatment-based use cases? Sorry, the current USCS.

Andy Truscott
Yeah, maybe the word "aligned" versus "harmonized" **[crosstalk] [00:04:29]**.

David McCallie – Cerner – Public Member
Yeah. I like aligned because it's a timing issue as much as anything. You can expect interchange about something that hasn't yet been standardized on the data side.

Arien Malec – Change Healthcare – Co-Chair
Yeah, okay. And public health is one of those where it's -- I've been thinking a lot about Noam's proposed language. But public health is one of those areas where right now, each of the individual public health cases, have in some cases, separate CDA templates for them. Maybe we can make a comment on public health.

Noam Arzt – HLN Consulting – Public Member
Right. But in that case, remember, the public health permitted purpose is executed through the lens of what is legally permissible in the jurisdiction, and the notion that the minimum amount of information that public health requires is what's supposed to be transmitted. So, if that's what you're doing, for sort of lack of alignment, by definition, it's not completely aligned because it shouldn't be.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, Noam, just to gloss that more, the issue I think that David is pointing out, and this is a specific example of that issue, is that the U.S. core dataset that's defined for meaningful use is defined to apply to a fairly broad and nonspecific set of data attributes. But if you look at, for example, infectious disease reporting, or lab reporting for public health, or in any of the other additional public health use cases, they often require very specific subsets of data that include more data and more detail than are currently in the USCDS.

Noam Arzt – HLN Consulting – Public Member
Okay, that's fine.

Denise Webb – Marshfield Clinic Health System – Co-Chair

So, Arien, what we want to say is that the USCDI needs to be aligned with –

Arien Malec – Change Healthcare – Co-Chair
With each of the permitted purposes.

Denise Webb – Marshfield Clinic Health System – Co-Chair
For each of the permitted purposes.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, we make that case. We make that statement with respect to SSA, but I think David's pointing at a much more broad issue.

David McCallie – Cerner – Public Member
Yeah. And a friendly clarification for Noam's part. I was more thinking the USCDI than I was anything else.

Arien Malec – Change Healthcare – Co-Chair
Right. That's a key point.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Right. I think we're leading off with that, that the USCDI needs to be aligned around –

Arien Malec – Change Healthcare – Co-Chair
Exactly.

Andy Truscott
Yeah, we have a dependency upon that.

Arien Malec – Change Healthcare – Co-Chair
Right.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Okay. We have Mark in the queue next.

Mark Savage – UC San Francisco – Public Member
So, actually I'm realizing I'm not sure where we are. Are we at the recommendation on the top of the page that we can see? The one that begins –

Arien Malec – Change Healthcare – Co-Chair
Yeah. Should require individual access and treatment permitted uses and disclosures.

Mark Savage – UC San Francisco – Public Member
Okay. Then let me just put my hand down. But actually, I will add, I agree about aligning with USCDI, but flag whether it's also worth mentioning the 2015 edition and the CCDS, because there are some things that are seem to me at least to be resolved at this moment in time within the 2015 edition that are opened up a little bit with the USCDI. So, it seems like we'd want alignment with what's in structure and already designed, as well as what's to come.

Arien Malec – Change Healthcare – Co-Chair
Yeah, and it's not our role. It's really the USCDI taskforce that's supposed to be making comments on the USCDI. I think our role here with respect to the TEF taskforce is to note that we do need to align USCDI for each of the non-individual access and treatment permitted use and disclosures. I see Genevieve and then Noam.

Genevieve
Yeah. So, just one thing that you guys might want to clarify. There are two ways that you could be talking about this, and I'm not completely clear which way you're talking about it. There is the concept of you need to expand the USCDI to support a particular permitted purpose, which is one way to look at it. The other way that you could be talking about it is not all USCDI in the current list is required for each of the permitted purposes. And so, you could be talking about just trying to have a version of the USCDI for each permitted purpose, but with the existing USCDI version. And I don't know that you guys really were being quite clear on that.

Arien Malec – Change Healthcare – Co-Chair
Yeah. And I'm not sure at this stage that we – I mean, it's probably worthwhile making both comments. I think David's original comment on SSA that **Commonwell** had about taking USCDS and the profiled consolidated CDA, and noting that SSA in many cases was happy to get all the detail, but really needed all the specific detail relating to disability benefits adjudication. So, in most of these cases, not so much that people don't like getting the additional detail; they just won't use it. It's more that there's more specific detail that they need specific to disability benefits adjudication, or public health reporting, or risk adjustment, or **HEDIS** measurement, or etc. I can look at the same thing from a quality measurement perspective in the sense that the USCDA, USCDS, whatever it is –

Genevieve
I.

Arien Malec – Change Healthcare – Co-Chair
CDI. The consolidated CDS – the consolidated CDA. I'm getting so confused at this point. The consolidated CDA that conforms to the USCDS has sufficient detail to adjudicate many clinical quality measures, but it falls down in some very predictable areas. For example, any clinical quality measure that requires, for example, assessments and assessment data tends not to be well standardized with respect to quality measurement. So, again, each of these areas has their own set of issues where there's more specific data that's needed to do thing X that you're looking for. And so, Genevieve, I think that's more on the "you need more specific data" side, not that "you need less data" side. But I think it's probably worthwhile mentioning both.

Genevieve
Yeah. I think if you could just clarify that, and then the other sort of clarification maybe that was made at some point is are you saying that a permitted purpose shouldn't be supported unless you have all of that data, or are you saying you can still do the permitted purpose, but recognize you're going to need more data than that?

Arien Malec – Change Healthcare – Co-Chair
Yeah. It's more that, more the latter.

David McCallie – Cerner – Public Member
And regardless, they have to be in sync. And you could scope one up or scope one back to get them in sync. But it would be ill-advised to expect broad scale exchange for a permitted purpose for which there isn't an agreement on the data to be exchanged. It's a tautology almost, but it does warrant being called out.

Male
Yup. But also to know one of the points about the common clinical dataset is it was supposed to go around. It was supposed to be available with all of the referrals and transitions of care, and it was supposed to be available for individual access. It was a common clinical dataset, so I'm not sure where the notion of limiting it, of carrying it down for particular permitted uses would make sense. It doesn't make sense to me.

Arien Malec – Change Healthcare – Co-Chair
Well, I think the goal is to be expanding it, actually. **[Crosstalk] [00:13:07]**

David McCallie – Cerner – Public Member
Specific needs that are missing.

Arien Malec – Change Healthcare – Co-Chair
Agreed.

Andy Truscott
Should we be clear that we are not going to seek to define what the dataset is? Do we leave that fundamentally to the USCDI as part of their data definitions for any particular domain?

Arien Malec – Change Healthcare – Co-Chair
Correct. We're just noting that alignment is necessary. Yeah, totally. Okay. I want to get back onto the – because we do have a queue, and let people who are patiently raising their hand to actually get the benefit from it. So, Noam, David, and then Mark.

Noam Arzt – HLN Consulting – Public Member
Yeah, just real quick on this. And I'll go back again. There is actually, in the public health permitted use, there are times when public health does not want everything in that dataset, and/or cannot legally have everything in that dataset. So, that is a factor. So, I think the USCDI door swings both ways. There are times when you need more that's in the dataset and there are times where you should send less than what's in the dataset.

Arien Malec – Change Healthcare – Co-Chair
Right. And there's also a HIPAA minimum necessary that comes into play here.

Noam Arzt – HLN Consulting – Public Member
Yeah. Which I think is important. It's not clear to me that anyone abides by it.

Female
So, there's cases where it needs to expand and cases where it needs to contract.

Arien Malec – Change Healthcare – Co-Chair
Yup.

Female
Okay.

Noam Arzt – HLN Consulting – Public Member
Right. But I don't want to ignore the contracting one, because at some point, a couple of people said, no, you should always send sort of the base case. And at one point, Arien, you said, well, nobody sort of cares if they get extra data. Well, I don't think that's true, actually. I mean, look at these gigantic clinical summaries that come.

Arien Malec – Change Healthcare – Co-Chair
Absolutely fair. Yeah, so absolutely fair. I think this dialogue has been very enlightening and incredibly helpful. Let's go to David and then Mark.

David McCallie – Cerner – Public Member
Okay, so I'm gonna change the subject, if that's okay, to this question about the particular recommendation here. And it's a wonky point, and maybe it's not worth calling out. But I made a note in my own notes, so I'll mention it, which is that in the **Proagamana** right before this recommendation, there's some discussion about the fact that patients might have been identity proofed into their own portals at different levels of assurance than would be required by other providers and their portals, and that that information is not currently being communicated. But we don't mention that in the recommendation. And I'm wondering if that's worth calling out, that profiling should include better constraints on how level of assurance is communicated across requests, or is that just too wonky for where we are?

Arien Malec – Change Healthcare – Co-Chair
Yeah, that was the intent of "that are sufficient to enable broad scale individual access." But it might be worthwhile putting in a little parenthesis.

David McCallie – Cerner – Public Member
Yeah, maybe a parenthesis that's sort of including clarification on levels of assurance or required minimum levels of assurance, or something like that. Or communicating levels of assurance. It just seems like the point got dropped. That was my only concern.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, parenthetical e.g. Yeah. Okay.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Arien, I think Mark's next in the queue. We did get some comments from Mark, and I don't know, Mark, if you're gonna mention that you had highlighted on this recommendation that you had said no to the "other uses and disclosures require broader scale testing or require additional standards and policies, and subsequently should be phased in later." I'm not sure what you were saying no to, so maybe you can address that when you speak.

Mark Savage – UC San Francisco – Public Member
That was exactly – I find myself still a little disoriented, and I'm sure it's just me. But so, I think I'm going back to make sure that me – because I don't think we had closure on the previous recommendation, if I've got our current place correct, which is the one that says, "ONC should require individual access and treatment. Other uses and disclosures require broader scale testing and require additional standards and policies." I remember that we were talking about this on Friday. I don't remember that we had closure on that on Friday. I'm happy to address that further if this is the time.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, if I remember the conversation that we had on Friday, it was wanting to make sure that we were clear that at this stage, we're not prioritizing saying X use case is more important than Y use case. We're saying X use case is ready to go nationally. Y use case is not ready to go nationally. And those are two very different statements. And maybe that context did not get in. Clearly, that context did not get into this current draft.

Mark Savage – UC San Francisco – Public Member
Mm-hmm. So, I mean, I'm looking at the current language, which does say we should go with some, and others need to wait. And that's in the comments that I shared over the weekend. I pointed out that the definition of each of the permitted use cases refers to existing activity that has been going on for a while, and so it doesn't make sense. And the draft that came out did not prioritize the six use permitted purposes, but instead said they are all six permitted purposes. So, I would suggest that we not talk about some are ready for prime time and others are not ready for prime time, just to shortchange the phrase.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, that would be an area where I'd personally – I think it would be useful to get additional feedback. It'd be an area where I would – I personally believe in the statement that we're making, that some permitted purposes are well tested and other permitted purposes are not well tested. I see David and John have their hands up.

David McCallie – Cerner – Public Member
Yeah. I mean, I do think we need some staging and prioritization. I think that was the purpose of our vote on the meeting of the on-ramp to some degree, or recognition that maybe it's not right to start by trying to do all these things all at once. And I think it's extremely important to acknowledge the things that are well understood and tested in real world deployments versus the things that aren't yet tested, and don't treat them as equal in terms of looking for early returns on the investment in the TEF. So, we've talked about a floor, and staging, and testing, and evolution of use cases. I think that's the only practical way to go. It doesn't preclude doing anything. It just says do it in a thoughtful, step-wise manner that the industry can participate in and keep up with, so.

Arien Malec – Change Healthcare – Co-Chair
Yeah, and David, just the gloss there is that that point can be easily misinterpreted, so I think it's very important that our recommendations make it clear, the distinction between prioritization based on level of testing versus prioritization based on level of need and importance. And in this recommendation, we're really focused on prioritization based on level of testing. And we could have taskforce disagreement on whether other permitted purposes are well tested, but that's a different point from saying in some sense, one's more important or one's less important.

David McCallie – Cerner – Public Member
Yeah. I agree. All those are independent factors that need to be aligned. Witness the Dixie Baker paper and many other work that was done in the past on ensuring that systems are ready to do the intended purpose before you actually expect them to do it.

Arien Malec – Change Healthcare – Co-Chair
Okay. John?

John Kansky – Indiana Health Information Exchange - HITAC Committee Member
Yeah, thanks. I'm weighing in, I think, in general agreement with Arien and David. Hopefully I'm not stating the obvious, but the desire or the recommendation to ONC that things be prioritized, staged, tiered, whatever it is, is in the best interest of success. I mean, I think I speak for myself only, but I think others, this is still the logic behind some aspects of suggesting prioritization is that we don't think we can eat the sandwich in one bite. We don't think the nation can eat this sandwich in one bite. And therefore, we're trying to provide recommendations that are in the best interest of TEFCA being accepted and adopted.

Arien Malec – Change Healthcare – Co-Chair
Thank you. By the way, I see in the chat somebody asking the question about the minority and majority recommendations. We should probably go back to that. I believe at this stage, we have the answer to the question, is if position two and position three are combined, does it become a majority opinion? And the answer is right now, the best we can do is a 50 percent split. So, with regard to people who are concerned about labeling majority/minority, we will not, in the final version or the next version of this – which seems to be the final version, or at least pretty close – will not label either of these recommendations as majority/minority. Instead, we will represent the taskforce as essentially split on this issue.

Denise Webb – Marshfield Clinic Health System – Co-Chair
And Aaron, does that mean we're dropping the third? I know Noam suggested in his written comments to us that there was three, and that we drop the third entirely.

Arien Malec – Change Healthcare – Co-Chair
I believe that the third actually had the second most number of votes. So, I think the suggestion on the floor would really be whether you combine the second and the third into one, effectively into the third.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Oh, okay. Maybe that's what he was saying.

Noam Arzt – HLN Consulting – Public Member
Well, it's confusing, Arien, because at one point, you reversed the order in the draft. So, now I'm not sure what anyone means by second or third.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Oh, okay.

Arien Malec – Change Healthcare – Co-Chair

Okay, yeah. So, let's define the ordering right now as – or maybe we just provide appropriate labels. But there is essentially the concentrate on nationwide query position. There is the concentrate on nationwide query and other high priority use cases or other high priority needs towards – Noam, your reformulation of that is concentrate on nationwide query and other forms of exchange necessary to achieve the permitted purposes. And the last position is establish a true single on-ramp with respect to all forms of exchange. And so, right now, the voting is effectively half of the taskforce has voted for the focus on query-based exchange, understanding that that may not be 100 percent sufficient for all of the permitted use cases or all of the purposes. Second most number of votes on establish a true single on-ramp for all forms of exchange, and then a couple of votes for focus on query and other capabilities as necessary to achieve permitted purposes. So, anyway, that's the current standing. Lauren, based on how we've counted all the votes, do I have that wrong? I want to make sure that we're –

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yup, that is correct. And we do have one member that did not vote, so.

Arien Malec – Change Healthcare – Co-Chair
Okay.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Yeah. And I think that's the order we do currently have, then. It goes from just query-based to the whole kitchen sink to underserved high priority areas. I think that was the one that had two votes.

Arien Malec – Change Healthcare – Co-Chair
That's right.

Denise Webb – Marshfield Clinic Health System – Co-Chair
And that's number three that Noam's referring to in his notes.

Noam Arzt – HLN Consulting – Public Member
Yeah. So, I'm still a little confused about all this, but I'm just going to go back to cover my own notes.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Okay.

Arien Malec – Change Healthcare – Co-Chair
Okay. But again, with respect to this, the final draft notes, we'll not use the word majority, because we haven't established that. I think it's fair to say that the taskforce is essentially split on these issues.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Yup.

Arien Malec – Change Healthcare – Co-Chair
Jonathan, did you mean to put it down, or did you mean to be back in the queue?

John Kansky – Indiana Health Information Exchange - HITAC Committee Member
I just put it down.

Arien Malec – Change Healthcare – Co-Chair
Thanks. All right. Let's go to the SSA case, which I think is effectively a subset of the broader case that was just discussed, so it needs to be revised to indicate the broader case. Is that a fair statement of the sense of the taskforce?

Denise Webb – Marshfield Clinic Health System – Co-Chair
That's what I was hearing, Arien.

David McCallie – Cerner – Public Member
One more time, Arien? I was distracted.

Arien Malec – Change Healthcare – Co-Chair
The SSA comments here end up being subsets to the broader discussion that we just had relating to aligning the USCDI with each of the use cases beyond individual access and treatment.

David McCallie – Cerner – Public Member
Yes, although the fee discussion is different.

Arien Malec – Change Healthcare – Co-Chair
The fee discussion. Yeah, so.

David McCallie – Cerner – Public Member
I mean, there is a fee discussion with individuals also. Actually, both of them have a fee discussion, but different points being made.

Arien Malec – Change Healthcare – Co-Chair
Yes. So, there actually is a whole cluster of issues relating to USCDI and a whole cluster of issues relating to fee disparity issues. I think the fee disparity issues are clearest with SSA because they've established a common and transparent fee structure.

Denise Webb – Marshfield Clinic Health System – Co-Chair
So, Arien, maybe what we should do is split this recommendation and take the portion out about the USCDI and make that a separate recommendation, and then have the one on the fee disparities.

Arien Malec – Change Healthcare – Co-Chair
Yes, I think that's appropriate. Now, we have a whole set of issues relating to the payment use. And this relates to the discussion that we had as a taskforce that noted that there are a variety of payment-based uses, and each of them is slightly different. So, we in this draft note, claims attachment, medical necessity, utilization management, risk adjustment. We should probably have added in that exemplar list quality measurement. Although maybe the intent in this current draft, thinking about how I drafted it was to push the payment-based use cases to the operations use cases. And I need a HIPAA lawyer to let me know whether HEDIS measurement is considered a payment-based use case or an operations based use case.

Genevieve
Hey, this is Genevieve. Anything quality measurement-related is operations, typically per guidance

from OCR.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, even if a payer's doing the –

Genevieve
Yup.

Arien Malec – Change Healthcare – Co-Chair
Yeah, okay. So, that's what the current draft recognizes, somewhat inconsistently.

David McCallie – Cerner – Public Member
But Arien, do we really care, payment or operations-based?

Arien Malec – Change Healthcare – Co-Chair
No. I'm just trying to remember, frankly, why I wrote it this way and why I didn't include HEDIS measurement. And it was that exact point that caused me to push HEDIS measurement to the operations section. So, point one is that payment use cases or payment uses have a lot of specificity associated with them. There's not one thing that's payment. There's a whole bunch of sub-uses that are defined as payment. Some of those payment cases require individual member-level access. Other require population-level data access.

If you go down to the next page . . . Population-level queries for payer-based use cases may require member filtering and other mechanisms to address policy requirements when patients move between payers and plans. So, the key point here, and this came out of a comment that Dave had made, is that when you are doing payer-based use cases, you're not just asking for a set of patients, you're actually asking for a set of members who are currently applicable for the level of query that you're trying to do. And there's a whole thing, as I think people recognized right now, of contractual requirements for payers and providers, that if you go to duty to respond, open data access is probably not a well-formed term. If you go to duty to respond, you could get in the way of those contractual requirements in somewhat interesting ways. And the recommendation here is ONC should clearly define set purposes to be used under the broad payment permitted purpose and define the policy objectives. ONC should work with the RCEs to establish enablement, including standards implementation guidance, policy guidance, profiles for each of the permitted purposes for which duty to respond is required. Thoughts? Hands? David put his hand up. Yes? And commenting, go.

David McCallie – Cerner – Public Member
I think you captured it somewhere, but I can't find it. The payer relationships sometimes have contractual limitations as well, in addition to the member. Did you capture that somewhere?

Arien Malec – Change Healthcare – Co-Chair
Yeah, that's that last clause. "In many cases, payer provider data query have additional." And again, that sentence is really poorly written. "In many cases, payer provider data queries have additional contractual requirements, and the relationships between payers and providers can be substantially affected by duty to reply, TEF duty to respond.

David McCallie – Cerner – Public Member

Got it, thanks. That is what I was looking for.

Arien Malec – Change Healthcare – Co-Chair
Yup. Okay. With no additional hands, we'll go to the next one. And we make a distinction here between – so, this is where we punted HEDIS measurement. We make a distinction here between provider-based population-based query and payer-based population-based query. The query needs are similar, but the reciprocity and alignment of value and other kinds of surrounding issues are different.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Hey, Arien? Earlier, we changed the phrasing on common carrier requirements, but we didn't change it here, so we might want to make a note on that.

Arien Malec – Change Healthcare – Co-Chair
Good point. Okay. So, number one, we make a distinction between provider-based and payer-based population-based queries. We note that payer-based quality measurement and especially population data queries for evaluating physician performance. And just to back out, there are two defined uses under HIPAA operations that allow for aggregating of data. And broadly defined – there are a bunch of sub-definitions – but broadly defined, there are two operations uses that allow for combining of data across our quality measurement and measuring physician performance. And we're noting here that on the payer-based use of population data to establish physician performance, has even more of the marketing contractual issues that we noted in our recommendations for payment-based use cases. So, I think that's somewhat mildly written. I think provider's heads would explode if the net of TEF would be to allow payers to arbitrarily access data, population-level data, that allowed for the provider to, for example, make determinations for narrow networks and the like.

All right. And our recommendation here is "ONC should work with standards development organizations of public and private stakeholders – for example, **Argonaut** Project and/or the **DaVinci** Project" – and these are examples – "to define, test, collect feedback, and refine standards for population-based query for provider-oriented value-based care cases. ONC should work with HHSOCR and other stakeholders to align standards of policy requirements to ensure the standards can be used in practice. ONC should delay implementation of these uses until appropriate testing can be performed." And I see, having read this again, that nowhere here do we talk about payer-based cases. I see David has his hand in the queue, and anybody else who wants to comment, please put your hand in the queue. David, go.

David McCallie – Cerner – Public Member
Yeah, it's David. My concern is that the distinction between these two population use cases is not clear to me, and maybe an additional sentence clarifying what you mean when you talk about payer-based or provider-based population queries. I missed that completely when I read it, so I just think it needs a bit more explanation.

Arien Malec – Change Healthcare – Co-Chair
Do you understand it now based on the discussion that we've had, or is it something where –

David McCallie – Cerner – Public Member
I think so. I need to think about it a bit more because I missed it the first time. I think I do. And then I had a second, somewhat unrelated comment. I think it's redundant to what we've said already. But the

standards necessary to implement population queries, in addition to being incomplete, as the Fire bulk query work is still quite incomplete, it may not be compatible with the broker architecture defined for QHINs, and therefore needs a caution that it might require different technical approaches. I think we've covered that elsewhere, but.

Arien Malec – Change Healthcare – Co-Chair
I think we've covered that elsewhere by recommending that we defer the technical details.

David McCallie – Cerner – Public Member
Right. So, maybe just a note upward to that, as discussed elsewhere, technical details to support population query may be different than the individual patient.

Arien Malec – Change Healthcare – Co-Chair
So, just to gloss the first point, and acknowledging that the current draft doesn't make this clear, and seeking clarification from the taskforce about whether we should – whether this makes sense and is worthwhile, including in the taskforce recommendations, there are a number of needs for population-based query. But there is at least some level of distinction that can be made between the organization that is making the query and whether that organization is effectively an organization of providers in an ACO use case or other value-based care-enabling use case, where the organizations doing the query are generally not for profit associations or linkages of individual provider organizations. And where those queries are effectively being done on the provider's behalf in order to measure and improve quality measurement that the providers have contracted for. And similar cases where those population-level queries are made on the behalf of a payer.

And I understand in this world, the distinction between a payer and provider are getting blurred somewhat, but I'd also note from my own experience that there is a different level of sensitivity that provider organizations have with respect to ACOs or other value-based care organizations that they are participating in or clinical integrated networks that they're participating in relative to the same level of the inquiry by an insurance organization, a Blue, a National, etc., for the purposes of, particularly, risk-adjudication; or even more particular, determination of physician performance relating to network size; and even more particularly, relative to payment rates. So, that's the distinction that this draft is trying to make, is that there are some level of population-based queries where provider organizations effectively already are banding together in order to drive value-based care and other queries where there is some level of, as it were, an adversarial relationship. And that even though the underlying base query may be effectively, from a technology perspective, the same level of sensitivity and level of preexisting contractual issues may well be different.

So, I'm not hearing a ton of – if folks want to get in the queue and discuss whether that's an important point to make in this draft?

David McCallie – Cerner – Public Member
Arien, we're having a bit of a discussion in parallel in the chat session. It's sometimes hard to follow both. Do you envision that a single provider or a provider operating on behalf of his group could issue a population query to the payer community and expect to get back data about a population his or her panel of patients? Is that the symmetry that you're looking for?

Arien Malec – Change Healthcare – Co-Chair

It's a really interesting case, and actually, it'd be one where I'd love for Genevieve to comment or somebody else on the ONC side to comment. It does seem to me that there's some level of a duty to respond that is reciprocal in nature for anybody who's participating via QHIN, so that if a payer participated, they would have to be open for query.

Genevieve
Yeah, this is Genevieve. That is accurate to the way we envisioned it. And I've been very upfront about this: payers really want the clinical data, but providers really want the administrative data, because they need to do some of the same things. And so, there is a reciprocity requirement that if you are on the framework, you are providing that data as well, which is also why we renamed USCDI, because certainly a bunch of those data classes that are in the USCDI are also in the administrative data, and providers might want to be able to get that from payers.

David McCallie – Cerner – Public Member
That's good to hear and makes total sense. Then the secondary question, and maybe this is a deferred technical detail, but population bulk queries in both directions reciprocally also, or not?

Genevieve
We said both, but it's up to you guys if you want to recommend a variation there.

David McCallie – Cerner – Public Member
I don't think we know how to do either one yet, so.

Genevieve
Well, let me be clear. That was a future use case in one sense anyway, is that you – yeah, we work from a perspective of the minimum required terms and conditions, splitting hairs over that.

David McCallie – Cerner – Public Member
Well, I would certainly favor both. And when standards and testing warrants it, I think it makes good sense for a provider's panel to be query-able of the payers as well as vice versa.

Arien Malec – Change Healthcare – Co-Chair
Yup. And again, just to note that in cases of ACO enablement, payers already provide providers with the adjudicated data in order to do the activities that are contemplated under that contract as established through contract. But payers do not currently make their member panel data available ad hoc for population-level query for organizations that aren't participating in contracts. So, we could probably make some of the same comments relating to the somewhat tangled thicket of contractual requirements relative to the much broader and more open access contemplated under the TEF.

Okay. So, with regard to the recommendation that I previously read, I'm not hearing a ton of edits to the recommendation, except for the notes that we've already made. Waiting two beats. All right. Let's go on to privacy and security. So, number one is we basically note that there's a fairly complicated history here in terms of collection of individual consent or – David, what did the privacy and security **TIGER** team call it? There was a rather lovely term that the TIGER team –

David McCallie – Cerner – Public Member
Meaningful choice.

Arien Malec – Change Healthcare – Co-Chair
Meaningful choice.

David McCallie – Cerner – Public Member
Meaningful choice, yeah. That's right.

Arien Malec – Change Healthcare – Co-Chair
But the whole cluster of activities relating to meaningful choice . . . We generally are recommending that it is best because there is no one broad national set of policies that magically dot every 'i' and cross every 't'. It is generally best to design standards approaches and policy approaches that push that responsibility as close as possible to the locus of care and as close as possible to the provider organization or other organization that is responsible for adhering with state and local requirements. So, our recommendation in this area is that ONC should not demand universal requirements to collect and honor individual consent for HIPAA permitted purposes. ONC should assign requirements in this area for the RCE to address, which the – again, poorly written. The RCE should consider successful implementations that allow flowing/assigning those requirements to the provider organizations. And this probably should be glossed, as closest to the state and local requirement.

So, David, I see your hand's in the queue.

David McCallie – Cerner – Public Member
Yeah. I agree with this recommendation. It sounds good. Maybe I'm again being redundant, but in the draft language, there was quite a bit of technical detail about QHINs holding electronic records of consent status and having certain duties around implementing them, and it was pretty confusing, given current standards, as to how that would be accomplished. I agree with the policy goal here. I'm concerned that the technical details suggested in the draft are beyond current capabilities.

Arien Malec – Change Healthcare – Co-Chair
Maybe the recommendation should note that ONC should not demand universal requirements, including policy and technical enablements.

David McCallie – Cerner – Public Member
Yeah, until well-defined standards allow it. I mean, people have proposed all sorts of things in the past, but none of them have been scalable. We've had many consent capture efforts and standards work, but none of them have scaled. So, we didn't bring it up. It wasn't one of our questions to address in the work group, but it was the biggest sort of red flag to me when I read the draft around technical gaps.

Arien Malec – Change Healthcare – Co-Chair
Okay. This conversation has caused two more hands to raise. Carolyn and Aaron.

Carolyn Peterson – Mayo Clinic Global Business Solutions – HITAC Committee Member
Great. Thanks, Arien. In looking at this, I get the sense that this is a pretty general kind of recommendation when we think about all the different types of data that could be going back and forth. I'm wondering if we want to say something about kinds of notifications, or what sort of provisions, what the privacy expectation can be when they are submitting patient-generated health data for a particular purpose to a particular recipient? Do we want to say something about should

patients expect that if they send some kind of PGHD, that it's going to be made available to anybody or usable by anybody for any purposes? Because I think people understand HIPAA and what it means when you're at your doctor's office signing off on HIPAA, but I don't think people have necessarily thought about what it means to have something that you intend to go to your doctor and go to the insurance company.

Arien Malec – Change Healthcare – Co-Chair
So, Carolyn, we do note in previous sections of the document that duty to respond should not be assumed or obligated on patients; that they may choose to respond, they may choose to make their data available for broad scale response, but they should not be inadvertently or explicitly required to do so. At least in that sense, what we do say is that it really should be up to the patient's control about how broadly they do or don't want to share PGHD or other data.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Arien, but I think isn't Carolyn saying once that data is provided, where can it go, if it's patient-generated data?

Arien Malec – Change Healthcare – Co-Chair
That's a very different and really complicated area. There have been, as David notes, a variety of activities that drive segregation of data, particularly for SAMSHA data, but in this area, one might want to contemplate segregation of data for patient-supplied data. The basic issue in this case, as I think Dave would note, is we have standards-ish, but we don't actually have the policy enablement to make those standards actually apply in practice.

David McCallie – Cerner – Public Member
David. I would agree with that, and also add the patient-generated data and things like correspondence between a patient and a provider are not, I don't think, in any of those efforts to **consent** standards. Yeah, the point about sharing with a payer is a really interesting point. Does private correspondence with a patient get shared as part of the USCDI duty to respond? I don't know.

Arien Malec – Change Healthcare – Co-Chair
Yeah, I'll just refrain from comment here, because I could comment, but I think we're gonna go down a big rabbit hole.

Carolyn Peterson – Mayo Clinic Global Business Solutions – HITAC Committee Member
Well, I absolutely agree that it's very complicated, and it's something that hasn't been able to be resolved very well elsewhere, so it would be hard to kind of fully resolve the question here. But I do think it's fairly critical for ONC to have something to say about what we can understand its expectations to be around consumer and patient privacy with regard to personal data, even though it can't dictate the world today. Because as we've seen repeatedly, patient data and consumer-generated data, through all sorts of new consumer health tools, has a very significant monetary value. And if nothing is said, then that kind of leaves the door completely open for all sorts of things that we understand implicitly we don't want to see, but could happen because it hasn't ever been noted anywhere else that those things should not happen. And it's not ONC's expectation that they happen. Or conversely, if it is ONC's expectation that it's just fine for the sale of the stuff and the free flow to places where patients or consumers didn't expect it, that should be noted too.

Arien Malec – Change Healthcare – Co-Chair
Hold on, guys. Hold on. Hold on. Stop. So, I'm gonna – unless Denise overrules me, I'm going to ask or note that this topic is really outside of the boundaries of the TEF. It wasn't one of the questions we were asked to adjudicate. It wasn't one of the – it's a really complicated set of items that have legal – both HIPAA and **FTC** legal considerations applied to it. And so, I think it's appropriate as a taskforce that we've noted that on the patient side of the TEF or the query angle, patients should be in full control of their obligations to share. And I would recommend that we just stay out of this topic.

Aaron
And this is Aaron. Let me just quickly comment. I was gonna actually go down that direction with you. I also think perhaps maybe we want to consider notating that perhaps ONC could work with OCR on further refining maybe standard practices or guidelines for how to deal with this and deal with patient data in the future, much like we did the standards component of this earlier.

Arien Malec – Change Healthcare – Co-Chair
Yeah. And we do note in the next section that we're about to talk about that with both, with regard to patient education on rights and responsibilities, it's a critical area, that ONC's created important resources in the model privacy notice, and we recommend that ONC should provide existing background to the RCE, if not otherwise constrain requirements for patient education and patient matching. Is there something more that we want to say that's more affirmative that ONC and OCR should – we recommend that ONC and OCR –

Aaron
Partner to further –

Arien Malec – Change Healthcare – Co-Chair
Yeah.

Aaron
Offer additional guidance, further educational materials, whatever. But I think calling attention to OCR, particularly given how difficult the landscape could be to what you noted earlier, is important, because they are brothers in arms together organizationally.

Arien Malec – Change Healthcare – Co-Chair
Okay. So, the whole cluster of PGHD donation into the ecosystem?

Carolyn Peterson – Mayo Clinic Global Business Solutions – HITAC Committee Member
Yup, sounds fair.

Arien Malec – Change Healthcare – Co-Chair
Okay. And we'll clean up the language. All right. We are done.

Sheryl Turney – Anthem Blue Cross Blue Shield – HITAC Committee Member
I had my hand, sorry.

Arien Malec – Change Healthcare – Co-Chair

Okay. Hey, Sheryl, go ahead.

Sheryl Turney – Anthem Blue Cross Blue Shield – HITAC Committee Member
So, I'd chime in. One aspect here, and I'm not sure that the comments on that recommendation really addresses it, but that we find a lot of members or patients are giving their login data to the automated bots. And somehow, we, I think, need to speak to that here, because at the end of the day, I'm not sure how we're educating them to help them understand the danger of doing that. And so, I do agree we need to have that education and have something more than what is currently set. But I think specifically, patients/members need to understand the danger that they face when they're entering into an agreement with an entity that they may not know that well. And maybe they think they do, but maybe they don't really know how that entity could potentially use their data.

Arien Malec – Change Healthcare – Co-Chair
So, I would say at this stage that to the extent that we've made recommendations in this area, we've pointed to the **Smart on Fire** work that does not require sharing of these names and passwords, and uses **OAuth2** and open ID connect to establish time-limited authorizations for patient data. So, in some sense, I think we already pointed to recommendations that acknowledge that patients should be in full control and shouldn't hand over credentials in an open-ended way and non-time-bound way. Again, there's always – if we're making comments about this, is that really relevant to the recommendation we're actually making? And I think in this case, we're making recommendations that the individual consent side and the individual authorization side should follow best available standards, which certainly would not include handing over credits to a third party.

Sasha, you put your hand up. I wonder if you've got additional comments in this area or something else.

Sasha TerMaat – Epic – HITAC Committee Member Thanks. Did we land on adding a point about the scope that we addressed in the taskforce and the scope we haven't addressed in our recommendations, our did that get morphed into another point? I kind of liked that it's clarifying it, and I wasn't sure if we landed on actually including it.

Arien Malec – Change Healthcare – Co-Chair
Sorry, can you . . .

Sasha TerMaat – Epic – HITAC Committee Member
Yeah. One of the questions about the most recent recommendation that we were discussing, there was a point in the discussion that some of it was outside the scope of what we'd been tasked with in terms of the questions we'd been asked. And it sounded briefly like we might note that in our recommendation, just in terms of saying these recommendations are not necessarily inclusive of any possible content we might have been able to discuss because of time and our directive and so forth. Did we land on including that or no?

Arien Malec – Change Healthcare – Co-Chair
Yes. It's a great point. Let's include that, and in particular, let's include a lot of these fairly thorny topics relating to patient enablement of the ecosystem.

Sasha TerMaat – Epic – HITAC Committee Member
Sounds good.

Arien Malec – Change Healthcare – Co-Chair
I'm writing a whole set of words that hopefully I will be able to read. Got it. An hour left. There is a set of recommendations that no one has put together and drafted, and a set of language that Mark put together and drafted. We have yet to talk about public health. I want to be – because it's been a topic that there's been some degree of passion around, I want to make sure that we have the appropriate recommendation language in place for public health. And I think Noam established in his some of the meta-commentary that he put around the language. There's an odd issue in a sense that because we're sort of equally split on the constrain versus expand the single on-ramp concept, there's a conditional set of recommendations that we would have relative to if we recommend expanding, then we also need to contemplate or also need to make recommendations relating to the variety of push-based implementations for public health. So, it's almost like a conditional set of requirements that we might want to think about putting into this current draft.

Noam, I'll want to give the floor to you and maybe Mark as well because you both have thoughts in each of these areas.

Noam Arzt – HLN Consulting – Public Member
Yeah. So, I put my thoughts in the email. I must still say, though, that I am still a bit confused by this vote and what the vote really is. And I also myself don't see all that much difference between the second and third recommendations that were voted on. So, again, they've switched positions in different documents, so I'm not actually clear still on what the vote was, and I looked back, and I can't find any documentation of the vote at either, either in the minutes from the meetings or in any other correspondence. But be that as it may –

Arien Malec – Change Healthcare – Co-Chair
So, Noam, why don't we just hold there and just create clarity around that point, because it is – we collected – Lauren led the process to collect votes. We did voice vote during the meeting where we had this discussion. Noam, you weren't on that meeting. We followed up via email with you and with anybody else who wasn't on the taskforce call to better collect solicitation of the votes. Noam, we recorded your vote for the expansive option. I won't call it option three. And Lauren followed up directly with you to give you the opportunity to gloss or change that vote in any way that you wanted to. The results – and I think the fairest way to describe the results is the results were equally split between focusing on query and establishing some broader set of on-ramp that included exchange modalities beyond query.

And so, I think it's fair to say that we have an equal 50/50 split between those two positions, and that the formulation of the expansive position is clustered much more strongly on the broad and expansive single on-ramp. I think that's the fairest way to say where we are. But with regard to the taskforce, it's best to say that we're effectively evenly split, as opposed to – I think maybe you're concern that you're expressing is that we would use a division or fracture of the expand vote to indicate that the focus on query vote got the most or the plurality. And as I said, I think it's fairest to say that the vote was fairly evenly split between focus and constrain to establish towards a single on-ramp.

Noam Arzt – HLN Consulting – Public Member

Okay. And you would agree that the current draft document that we're looking at on the screen doesn't really express what you just said yet.

Arien Malec – Change Healthcare – Co-Chair
Yes. I would definitely agree with that, yeah. We were waiting on – again, note the flow of this. We were waiting on consolidation. There was a couple of votes, now one vote that's outstanding. I think we're just gonna proceed without, and just so you understand, when you're adjudicating between one vote in a 16-member panel, it is much more fair to say that we're equally split.

Noam Arzt – HLN Consulting – Public Member
Right. So, be that as it may, again, I think since the language was circulated today that I had written on Friday, that I would characterize as a fairly strong, fairly strident statement, I'm hoping, in essence. But it's the **[inaudible] [01:06:33]** one, hoping that that would sort of spur some conversation to see where we really wanted to end up here in the context of this sort of split. And I'm concerned that these thoughts are expressed, whether they're expressed in the form of a solid recommendation or simply expressed as part of the text of the document, I know that I have such strong feelings.

Arien Malec – Change Healthcare – Co-Chair
Okay. Would it be worthwhile just to address this topic, Noam, that number one, I think we've all agreed as a taskforce, we're gonna reflect an even split. Number two, with respect to the permitted uses section, it seems appropriate to establish a recommendation that if ONC . . . or as ONC and RCE, or some conditional statement. So, we recommend that ONC – if, conditional statement, recognize that a variety of other exchange modalities are necessary to achieve the stated permitted purposes. For example, in public health, push-based models – and we can provide some examples of push of reportable labs, push of reportable diseases, are heavily used. And we would recommend that with respect to this conditional inclusion that ONC, the RCE, and QHINs establish the appropriate exchange modality for those pushes. Is that – again, that's not as elegantly stated as we would do in text, but is that sense, Noam, the sense that you think would be appropriate to include in the recommendations itself?

Noam Arzt – HLN Consulting – Public Member
I think so. I mean, there's a lot of discussion in the chat. It's hard to sort of listen to the chat and look at the conversation at the same time. The bottom line is that public health is concerned about being essentially left out of this. Public health is not actually about the direct protocol, really, at all. And that's the primary technology that's used for these push transactions. So, in that respect, it's a little different than some of the other uses of direct. That's essentially the concern.

Arien Malec – Change Healthcare – Co-Chair
Yup.

David McCallie – Cerner – Public Member
I don't think anybody's confusing it with direct.

Arien Malec – Change Healthcare – Co-Chair
So, what I'm hearing Noam say, and this is actually relating to some points that the other folks have made, is that the TEF is a really important area of expansion of federal policy with regard to the information exchange. And if, to the extent that the TEF focuses on query-based exchange, there are a

number of participants, including public health, who feel very strongly that the net effect of that is to diminish the importance of those forms of exchange that require other exchange modalities. That's what I'm hearing from Noam. It's the sense that I've heard from other commenters in similar areas.

David McCallie – Cerner – Public Member
Arien? Would it make sense for Noam to summarize what he'd like to see the TEF contribution be? Because I'm not clear what the goal would be. What would TEF do that it has authority to do?

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, just to be fair, Noam put together some language here, and the language, I think, needs to be –

David McCallie – Cerner – Public Member
"Here" being where?

Arien Malec – Change Healthcare – Co-Chair
He put together some language that was sent to the full taskforce.

Denise Webb – Marshfield Clinic Health System – Co-Chair
It was emailed at the beginning of the meeting.

Noam Arzt – HLN Consulting – Public Member
Just as the call was starting.

David McCallie – Cerner – Public Member
Yeah. I haven't seen it, so maybe you could walk us through what your recommendation is in a couple of words?

Noam Arzt – HLN Consulting – Public Member
Can you put it up on the screen, please, **[inaudible] [01:11:19]**?

Denise Webb – Marshfield Clinic Health System – Co-Chair
Or I could read it.

Arien Malec – Change Healthcare – Co-Chair
Why don't you go ahead and read it, Denise?

Denise Webb – Marshfield Clinic Health System – Co-Chair
Okay. This is his recommendation. ONC should recognize that the core functionality required to fulfill the permitted uses defined in TEFCA is incomplete without the inclusion of the ability to push unsolicited data between participants. An important example of the need for this functionality is public health reporting, which is almost exclusively accomplished using push transactions between clinical care and public health agencies. Therefore, the TEF draft should be enhanced to require support for push transactions by QHINs as part of the floor, noting that this functionality is pervasive enough today as to be foundational. Significant progress has been made in standardizing public health interoperability technical implementation from jurisdiction to jurisdiction, and state and local public health agencies are working hard to align their requirements as permitted by law.

Arien Malec – Change Healthcare – Co-Chair
So, again, the intent of the formulation that I put out was an attempt to take that language and fit the less maybe passionate tone of the recommendations, but stay effectively the same thing. And again, it's conditional on adopting the expansive versus the query only focus, three-year focus for the obligation for the TEF and for QHINs, and note that if the more expansive three-year view is chosen, there are important push-based use cases that need to be contemplated and included. And in particular, there are a number of cases in public health – for example, reportable conditions and reportable diseases that would need to be accomplished through push-based use cases through the QHIN. And I think that level of recommendation is the appropriate set of recommendations that follow the rest of the taskforce recommendations in this letter.

Genevieve
Hey, this is Genevieve. Could I, I guess, ask a question? I'm not even sure if it's a question, but inherent in the recommendation that's up on the screen right now is that we are setting a floor. And this gets to what I was trying to ask in the chat. TEF is the floor, not the ceiling. So, is there room – and I'm genuinely asking as a part of the recommendations you guys are thinking of – is there room to require public health as one of the permitted purposes? So, you're enabling the policy side of the public health reporting piece by requiring it as a permitted purpose, but by allowing the support of the push functionality or trans support methods to be optional – so, some QHINs likely will, some won't, you're giving some optionality to the system so that not everyone will have to support everything. I guess that's kind of my question, is do you have to build the push modality into the minimum set of the modality requirements if you've dealt with the policy side of it, and then have an expectation that there are qualified HINs and folks in the industry who will do more?

Arien Malec – Change Healthcare – Co-Chair
So, Genevieve, I think that statement's actually already well reflected in the text. Based on previous taskforce language, it clearly indicates that we don't contemplate or we around recommending that the QHINs only do the floor, and that we think from a policy perspective, they should be able to do more than the floor. And there's specific language that we put in there that they should, and many will, choose to go beyond the floor. I think with regard to this language, it's noting that if ONC or other stakeholders choose the expanded on-ramp option, or one flavor of the expanded – some flavor of the expanded on-ramp option, that there may need to be a broader set of enablements for the floor that include standards certification requirements in areas such as push for public health messaging.

Genevieve
Okay.

Arien Malec – Change Healthcare – Co-Chair
Okay. We've got David on the queue. Yes, go ahead.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Arien, can I just add to that comment? Genevieve, the reason we got into this whole discussion in the first place is for the taskforce, it was not clear what the TEF really meant with this definition related to a single on-ramp. And so, as we got into the deliberation about that, obviously the taskforce fell across two positions. It really intended the floor to be query-based exchange in its first three years of progress versus the kitchen sink and everything, or some place in the middle above that floor query-based

exchange. So, I guess, depending on how ONC decides to approach that clarification of the scope of single on-ramp, it will dictate other things.

Genevieve
The centuries-old war between push and pull.

Arien Malec – Change Healthcare – Co-Chair
Yes, exactly.

Genevieve
We've been fighting for a long time, right?

Arien Malec – Change Healthcare – Co-Chair
All right. So, we're gonna get –

David McCallie – Cerner – Public Member
Call it a tug of war.

Arien Malec – Change Healthcare – Co-Chair
We're gonna get David, Noam, and Mark in the queue, and then hopefully close out this portion of the topic. David.

David McCallie – Cerner – Public Member
Yeah. We've been having a discussion in the chat session, so I'm gonna repeat a tiny bit of what I said there, just because it's hard to follow both. First, on the public health use of the query side of the network, I'm hugely in support of that and would expect public health entities to be able to query QHINs for appropriate information about their subjects to the degree that they're allowed to under law, immunization queries, etc. But the push side – and the whole value of a QHIN – let me just add a little footnote. The whole value of the QHIN network is the QHIN keeps track of where the patient has data available so it knows where to do the query. The push side is typically whether it's a V2 message, or a direct message, or a Fire post, typically has a sender and a receiver that are obligated under local jurisdictions as to they're allowed to send to and what they can send. And I think it would be very difficult to transfer that knowledge to the QHIN and expect it to somehow become a distributor of push. So, you're almost talking about a publish/subscribe model. And it's technically feasible, but does it actually add any value? That's what I'm not seeing. Compared to the complexity of –

Arien Malec – Change Healthcare – Co-Chair
David, I just want to note –

David McCallie – Cerner – Public Member
Clear. Push is not so clear to me.

Arien Malec – Change Healthcare – Co-Chair
I just want to note that the semantic content of your comment amounts to reaffirming your vote for the focus on query option.

David McCallie – Cerner – Public Member

Yup.

Arien Malec – Change Healthcare – Co-Chair
And again, just point out the taskforce is effectively split on that topic.

David McCallie – Cerner – Public Member
But I thought that's what we were discussing now, the value of push.

Arien Malec – Change Healthcare – Co-Chair
No, I think we're over that.

David McCallie – Cerner – Public Member
I'm sorry.

Arien Malec – Change Healthcare – Co-Chair
Yeah. So, again, I'll let Denise rope me in if I'm mischaracterizing the sense of the taskforce discussion. So, number one, we are over discussing that the broad topic of – so, we overall recommend that ONC should better define what it means by single on-ramp with respect to the task. That was a very clear taskforce recommendation. Number two, the taskforce is effectively 50/50 split on focus on query versus focus on a broad set of needs. We're now talking about language that amounts to if the focus on a broad set of needs is established, then there's a whole set of additional exchange modalities that need to be better specified – in particular, those related to push, and in particular, for those related to push, for those related to push for public health. So, that's kind of where we are right now in the sense of the taskforce discussion. And I don't think at this stage, we're going to crystallize the taskforce towards or against the effectively 50/50 split that we're in, so right now, we're recommending that we stick with telling ONC we're effectively split.

Okay. Noam, and then Mark. Noam, you might be on mute.

Noam Arzt – HLN Consulting – Public Member
Sorry. Maybe I've said enough, but I'd rather let the conversation go a little bit. Thanks.

Arien Malec – Change Healthcare – Co-Chair
Cool. Mark?

Mark Savage – UC San Francisco – Public Member
So, Arien, you mentioned my name as somebody to speak at this point. I'm not quite clear what you had in mind. I did send comments mostly in the form of sort of editorial. I don't think they were really substantive, except the one I already raised earlier in this call. But I did have some suggested additional – a few additional words around this particular point. Not to go to the vote, but just some context, like Noam's public health context. Is that what you wanted me to mention, or are we done with this conversation, and you don't want me to bring it up?

Arien Malec – Change Healthcare – Co-Chair
No, that was exactly the topic that I wanted you to address. I know you had some thoughts relating to, in particular, public health.

Mark Savage – UC San Francisco – Public Member
Well, I appreciate Noam's interest in making it clear why it's such an important piece without necessarily changing the vote. And I had a similar suggestion in the minority recommendation – whatever you're gonna label.

Arien Malec – Change Healthcare – Co-Chair
Right. We're not gonna label it majority/minority.

Mark Savage – UC San Francisco – Public Member
But in adding where it says "including push to public health, electronic orders, and results," to add the notion of referrals and transitions of care, just to illustrate the range of things that are important around this particular recommendation.

Arien Malec – Change Healthcare – Co-Chair
So, I do want to note that the current draft does note coordinated transitions of care as an important national priority. It's included in the expanded option.

Okay. I think we're through that discussion. And hopefully, the taskforce is understanding the set of recommendations we're make in this area. I generally believe that what we should do, as I noted, number one, is note that the taskforce is 50/50 split. Two is insert a recommendation in the permitted uses and disclosures section that notes that if the expanded – or maybe it should be right after the expanded on-ramp – but that notes if the expanded on-ramp option is selected, that there will need to be additional enablement. And we can give the examples of that enablement.

With regard to next steps, where the next step for this draft, we don't have much time at all, is to do another turn of the draft that includes numbering the sections and cleaning up the details. So, for example, putting in the references addressed in the language that we've talked about today, in particular the 50/50 split language, the language relating to other modalities of care, and the comments that we had to the section. At this point, the intent would be to turn another turn of this draft today. And I'd ask that Denise, myself, ONC team members be prepared to really quickly turn this out, give it to the full taskforce, be in the position to do a really quick turn as well. I think Lauren has indicated that although we really wanted to get recommendations out to the full committee today so we'd have time to review it before the committee meeting tomorrow, that we could do it tomorrow as well. I'd also note as being a committee member that we're really gonna be hurting ourselves by not giving the committee appropriate time to review. So, I'd like to ask, and understanding the quick turn that's required here, that comments be provided tonight or very early tomorrow so that we can get final recommendations out by noon. I'll look to Lauren to see if that plan makes any sense.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yes, Arien, I agree. The quicker, the better.

Arien Malec – Change Healthcare – Co-Chair
And by noon, I mean noon East Coast time, not noon my time.

Genevieve
This is Genevieve. The HITAC Committee is on Wednesday, right? Not tomorrow.

Arien Malec – Change Healthcare – Co-Chair
Yes.

Genevieve
Okay. I wanted to double-check. We at least want to give everyone as close to 24 hours as possible to review.

Male
So, Arien, can I recommend that you mention an explicit time that you need comments from taskforce members back so that we are all helping you, and everybody's clear on when that help must be given?

Denise Webb – Marshfield Clinic Health System – Co-Chair
Yeah, and time zones.

Arien Malec – Change Healthcare – Co-Chair
Yeah. I think it would be best to have comments provided well before 9:00 AM tomorrow, and comments would be best provided before 6:00 PM Pacific, 9:00 PM Eastern today. Does that make sense to people?

David McCallie – Cerner – Public Member
So, when are we gonna get the draft? Are you gonna send us?

Arien Malec – Change Healthcare – Co-Chair
As soon as humanly possible.

David McCallie – Cerner – Public Member
Okay. And then you want it back by 6:00?

Arien Malec – Change Healthcare – Co-Chair
Yes.

David McCallie – Cerner – Public Member
6:00 PM Pacific today.

Arien Malec – Change Healthcare – Co-Chair
9:00 PM Eastern.

David McCallie – Cerner – Public Member
In the form of just comments to the Word document, comments to the side or something like that?

Arien Malec – Change Healthcare – Co-Chair
Yup.

David McCallie – Cerner – Public Member
Okay.

Genevieve
And Arien, you're aware that Zoe is out of the office today, right? So, you're copying the other ONC folks on what you're sending out, right?

Arien Malec – Change Healthcare – Co-Chair
We'll make sure, Genevieve, to copy you as well.

Genevieve
That's great, thank you. And Lauren.

Arien Malec – Change Healthcare – Co-Chair
Yeah. Lauren always gets copied, no matter what.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Arien, we did get some public comment from Mark Siegel, and I sent it to you. And actually, I don't think that any of it is necessarily substantive, but they might just want to – I'd like you to look at it and see what you think. It's related to the RCE specifically, just those two pages.

Arien Malec – Change Healthcare – Co-Chair
I think – and Lauren, correct me if I'm wrong, but I think a general statement that all public health is welcome and useful.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Public comment, yeah.

Arien Malec – Change Healthcare – Co-Chair
Public comment, sorry. Thank you. And that the taskforce reserves the option to address that comment in drafting. I don't want to call or single anybody out, but again, thanks for Mark **[crosstalk] [01:28:17]**.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Yeah, Dr. Siegel gave some good suggested wording changes. But you look at it and see what you think.

Arien Malec – Change Healthcare – Co-Chair
All right. So, at this point, rather than spend the next half hour doing additional conversation, I think it would be useful, number one, to see if the taskforce has other drafting comments that haven't already been addressed.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Arien, I threw in the draft some comments that were just based on what I heard people say. I just want to see if people think that things in the draft, my comments can be deleted.

Arien Malec – Change Healthcare – Co-Chair
Yup.

David McCallie – Cerner – Public Member

Arien? One comment that I had made in an earlier run-through of this to myself – I don't think it's come back up – just put it in the back of your mind – is there are a couple of places where we discussed QHIN ability to do things that go beyond the floor, perhaps out of sync with other QHINs. And I wanted to just make sure that there was clarity that we thought that was okay, as opposed to something that would be prohibited by the common agreement.

Arien Malec – Change Healthcare – Co-Chair
That is in the draft.

David McCallie – Cerner – Public Member
Our draft, or the?

Arien Malec – Change Healthcare – Co-Chair
It is in our draft.

David McCallie – Cerner – Public Member
Do we need to discuss that at all, or did we have discussion I just don't remember?

Arien Malec – Change Healthcare – Co-Chair
We had discussion and we believe that that should be in there.

Male
That's my recollection.

Arien Malec – Change Healthcare – Co-Chair
Okay. So, here's the current text. "The TEF does not wish to restrict the evolution of the QHIN model over a longer period of time, or imply QHIN should offer only exchange modalities defined by the Trusted Exchange Framework. Some QHINs and EHR developers may be able to advance capabilities more rapidly for a broader single on-ramp. However, we would recommend the taskforce establish priority for floor services over the initial three-year period of the RCE cooperative agreement." And then this is where we go into the 50/50. And each of the non-expansive three-year priority cases note additional exchange needs may be satisfied by QHINs if they offer an exchange service above the floor and/or by their HINs.

David McCallie – Cerner – Public Member
Okay, so that sounds good. I think we could spend a lot more time on the subtleties of that, but maybe it's best not to.

Arien Malec – Change Healthcare – Co-Chair
Yes.

David McCallie – Cerner – Public Member
Then a second note to myself in the margins from a previous review, and I really hesitate to bring it up, but we talked about price structures and competition around QHIN to QHIN interchange. But if we really wanted to see a competitive ecosystem, you would have to have competition between participants and QHINs, which would imply probably some degree of standardization if you wanted the competition to be meaningful. And we don't address that. No one's addressed that. And I'm not really

sure I even would recommend that we do it, but it is a gap.

Arien Malec – Change Healthcare – Co-Chair
Yeah, it's definitely an area – that's right, exactly. I was thinking about direct. It's definitely an area that in retrospect, not specifying a single connection point to direct impeded the ability of the direct ecosystem to expand or establish price competition as quickly as we might have otherwise wanted.

David McCallie – Cerner – Public Member
And uptake probably as well.

Arien Malec – Change Healthcare – Co-Chair
Yup.

David McCallie – Cerner – Public Member
Because there was no standard.

Genevieve
This is Genevieve. Sorry, can you just clarify, are you talking about the fee structure, the pricing from qualified HINs down to participants and end users?

David McCallie – Cerner – Public Member
No. What I was getting at is the fact that if vendors and QHINs have highly evolved proprietary connections between them, it makes it very difficult for a competition between the QHINs to get the vendor's business. And absent that, there's not a lot of pressure to drive the cost of a QHIN to the participant down. Does that make sense? In other words, it's the other side. We've talked about QHIN to QHIN competition, but there's also competition QHIN to participant or QHIN to EHR. And to enable that would require a whole lot more standards work, and maybe it's not worth it.

Genevieve
So, the one thing I would actually say is limits on statutory authority, because when you look at Section 4003, I think is the number, for the Trusted Exchange Framework, it is very clear it is between health information networks. We have some statutory limitations, is what I would say, but if there are things in the certification side, certainly when that regulation comes out, that might be a place to comment on some of that.

Arien Malec – Change Healthcare – Co-Chair
Yeah. I would recommend that unless the taskforce broadly feels like this is a critical item that we missed that we should make recommendations on, I would recommend at this stage in drafting that we stay silent.

David McCallie – Cerner – Public Member
I'm okay to accept that, and I'm the one who brought it up, so.

Arien Malec – Change Healthcare – Co-Chair
And I believe just as strongly as David does that it was an oops in the direct case and probably will be an oops in this case.

David McCallie – Cerner – Public Member
Didn't see it in the charge to the taskforce.

Arien Malec – Change Healthcare – Co-Chair
And as Genevieve notes, very deliberately so. Okay. At this stage then, hearing no other taskforce members bringing up critical items that we missed, I'm gonna recommend that we go to public comment, and then that Denise and I go heads down on drafting mode. What I propose is that we will flip a red-lined and a clean copy draft to the taskforce as quickly as humanly possible.

Denise Webb – Marshfield Clinic Health System – Co-Chair
Okay.

David McCallie – Cerner – Public Member
But sometime in advance of 6:00 PM PT.

Arien Malec – Change Healthcare – Co-Chair
Yes.

David McCallie – Cerner – Public Member
Thank you very much. Thank you both for all the hard work, and ONC staff.

Arien Malec – Change Healthcare – Co-Chair
I did comment to the advisory committee that being a taskforce chair is probably the hardest and most thankless job of all of the jobs on the committee.

David McCallie – Cerner – Public Member
Well, I think you've got the thanks from all of us as committee members.

Arien Malec – Change Healthcare – Co-Chair
I appreciate that.

Denise Webb – Marshfield Clinic Health System – Co-Chair
And I'm thanking you as your co-chair, because you've taken on the lion's share.

David McCallie – Cerner – Public Member
If you want to remain thankless, I take it back.

Arien Malec – Change Healthcare – Co-Chair
Thank you, David. Well-played. Why don't we go to public comment?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sure. And just before that, I believe Genevieve had maybe additional comments before we go to public comment?

Genevieve

Yeah. I just wanted to make sure that I said thank you for all of your work. I understand that we put you guys to a task at an incredibly fast pace when you all have day jobs, and so I'm really grateful for all the time and effort and thought you put into this. And if it makes you feel any better, some of the conversations you guys had where you maybe ended up split are some of the same exact conversations that we had internally and ended up a bit split as well. So, I really appreciate the thoughtfulness behind it, and I look forward to seeing the final recommendations.

Arien Malec – Change Healthcare – Co-Chair
Thank you, Genevieve.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And operator, can we please open the line for public comment now?

Operator
Yes. If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 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 * keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you. And do we have any comments in the queue at this time?

Operator
There are no comments at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. We will conclude public comment. And Arien, if there's nothing else, we will adjourn. And it looks like we'll be hearing from everyone soon.

Arien Malec – Change Healthcare – Co-Chair
Perfect.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, thank you all. **[Crosstalk] [01:37:31]**

Female
Thank you.

Arien Malec – Change Healthcare – Co-Chair
Yup, thank you. Bye-bye.

Male
Bye.

Male
Bye.

[End of Audio]

Duration: 98 minutes