**Steering Committee AD HOC Meeting Minutes**

**July 25, 2018**

# Meeting Participants

| **Committee Members** |
|---|
| Nancy Beavin, Humana<br>✓ Bill Beighe, Santa Cruz HIE<br>Hans Buitendijk, Cerner<br>Michael Hodgkins, AMA<br>✓ Kevin Isbell, Kaiser Permanente<br>✓ Leslie Kelly-Hall, Healthwise<br>✓ Andrew Kling, Geisinger<br>✓ Rob Klootwyk, Epic<br>✓ Steven Lane, Sutter Health<br>✓ Kathy Lewis, Surescripts<br>✓ Tushar Malhotra, eClinicalWorks<br>Geoff Lay, GE Healthcare<br>Aaron Seib, NATE<br>Ryan Stewart, Dignity Health<br>✓ Steve Bounds, SSA(Ken Pearlstein for Steve Bounds) |
| **Invited Subject Matter Experts and Carequality Support Team** |
| ✓ Dave Cassel, Director, Carequality<br>✓ Chris Dickerson, Program Coordinator, Carequality<br>✓ Mariann Yeager, CEO, The Sequoia Project<br>✓ Eric Heflin, CTO/CIO, The Sequoia Project<br>Didi Davis, Testing Programs Director, The Sequoia Project<br>Jennifer Rosas, eHealth Exchange Director, The Sequoia Project<br>Dawn Van Dyke, Marketing Director, The Sequoia Project<br>Kati Odom Bell, eHealth Exchange Implementation Manager, The Sequoia Project<br>Alan Swenson, Kno2<br>Morgan Knochel, OneRecord<br>✓ Bill Mehegan, The Sequoia Project |

# Meeting Summary

## Call to order *1:03pm EST*

***Discussion Summary:*** Roll call was facilitated, and a formal quorum was established. The agenda was discussed.

***Decision/Outcome****:* The agenda was reviewed, and nothing was added.

***Action/Follow up****:* None.

### Agenda

- Roll Call, Agenda Review
- Admin Items
  - Meeting Minutes
  - Carequality Annual Meeting
- Technical Trust Policy
- Carequality Implementer Application
- Document Content Recommendations and Next Step
- Production Operations Update

## Administrative Items

- June meeting minutes were emailed for review. The July meeting minutes will be available during the next Steering Committee meeting. Kathy made motion to approve June meeting minutes. Andy seconded the minutes. All in favor, none opposed. June minutes approved.

### Steering Committee In-Person?

- Would the Committee like to have an in-person session at the Annual Meeting?
- The afternoon of Wednesday, October 24th is the most likely time

***Discussion Summary:*** Dave commented that the 2018 Annual Carequality Meeting is going to be earlier than last year. It will be held October 25th and the 26th at the Gaylord National Harbor in Maryland. The registration is now open. We are tentatively planning to have an in person meeting of the Steering Committee. Dave asked if that would be something of interest for this group. It would likely be the afternoon of Wednesday, October 24.

***Questions/Discussion****:* Steven commented that we had a good meeting last year and I would love to have a chance to see everyone in person.

***Action/Follow up****:* Dave responded that it seems we have support, so we will move forward with plans there for the in-person meeting.

**Brainstorming – Ideas for Discussion**

- We could consider increasing the size of the Committee
  – Based on experience it seems likely that a few more participants could be accommodated (e.g. increasing from 15 to 18)
- We could introduce limits that specifically seek to combat the perception of domination by particular vendors and their clients, such as:
  – If an EHR vendor has a seat, at most one of its clients may also have a seat
  – At most two clients of a particular EHR vendor may have seats
- Some key stakeholder groups currently have limited representation; we could consider mandating at least two representatives from some key groups, e.g.:
  – Payers/health plans
  – Patients/PHRs/consumer apps
- With the corporate restructure, the Sequoia Board seat may no longer be needed – although it may need to be replaced with a consideration for the Carequality Board
- We could consider term limits
- Other ideas?

***Discussion Summary:*** Dave commented that everything presented here is in the spirit of brainstorming and should not be considered a recommendation. This information is here solely as conversation starters.

***Questions/Discussion:*** A member commented we need to be aware that these changes are being considered because of Carequality will be a potential candidate for the RCE. The restructuring being done was stimulated by changes in the industry and the need to keep everything appropriately separated and aligned, but also to prepare us for the RCE bid. The changes that we make should be made with those opportunities in mind. It is interesting that we put 'patients and apps' on the same line. Patients and caregivers are one category and the people who are making apps to support them is a different category and would separate those. Expanding our stakeholder representation will make us better, whether or not we get the RCE role. That socio-politically puts us in a better position to make the bid successfully for the RCE and hope we can mitigate the perception of dominance by particular vendors and large health systems if we have the opportunity.

- Dave responded that maybe we can mandate more representation for payers, patients, app developers and treat the last two separately. We could explore forming a related block of the EHR vendors and large health systems.
- A member commented that I am interested in what Leslie and Morgan think about how to deepen patient, caregiver representation, and consumer facing app representation.
- Morgan responded that it seems like there needs to be more patient groups and patient representation. People who are patient advocates and there is a whole other group of people who are health advocates like caregivers. They are helping people to navigate their chronic illness and think that is a big community having had no say in terms of patient engagement within Carequality.
- Bill responded I agree with Morgan and Dr. Lane. This issue of patients, PHR's, apps came up at the very end of the last meeting. They are different and need different representation.
- Leslie commented in chat about the *All of Us* program.

- Steven commented that the *All of Us* program is a great suggestion. *All of Us* is a 10 year, NIH program that is the process of trying to enroll a million patients nationwide. The process when you enroll a patient is that they get your EHR data. They see you and get biometrics. They collect specimens and run your genomics and eventually send you questionnaires. They have great PR and graphics and stories online. If you haven't checked out All of Us research online or signed up as participant, do that because it is a great education.
- Dave asked if we have a contact there or if this is public info.
- Steven responded that they have tremendous stuff available online and anyone can go to the website.
- Leslie commented that it is all about supporting precision medicine with a focus on diversity of enrollment and working toward also collecting patients with rare diseases. There is an ONC liaison.
- Dave commented that would be great and would love to see us leverage Carequality connectivity to support that kind of work and that program in particular.
- Steven commented that his question about large versus small health systems and clients. All of us use the same EHR vendor. That is probably where that perception is coming from. We need to think creatively about how to reach out to smaller health systems. Could we work through the AMA or some of those specialty societies? Getting someone who represents small clinical practice would be valuable.
- Dave agreed and commented that we can do recruitment through Tushar and his counterparts at Athena and MGE, NextGen and Netsmart. I have also heard feedback that Hans and Ryan are part of the committee and it makes the block of large health systems and their vendors seem larger when you add that. *All of Us*, is a specific example of one that would be good and hit a combination of both research and consumer. It may not need an additional seat but could possibly replace something else. We would want to have an additional seat for a consumer focused effort and the specific suggestion of *All of Us* being an initial outreach target for that seat. There may be some interest in an additional seat if we want to look at the app developers. We have Morgan who happens to be an Advisory Council Co-Chair and if she weren't an Advisory Council Co-Chair, there would not be anyone from that perspective on the committee.
- A member commented that would be two seats. One representing the patient and one representing app developers/PHR's.
- Dave responded that would be three seats. One for app developers. One for patients that would be Leslie's current seat. Then an additional one for Consumer oriented efforts like *All of Us*.
- Bill commented his support for that scenario.
- Dave commented that Leslie's seat does already exist. It would be net two.
- A member asked about an additional payer seat.
- Dave responded that was discussed. Nancy was supportive of that idea.
- Leslie made a suggestion of someone to reach out from Blue Cross/Blue Shield. It would be worth considering smaller payers if we can identify some diversity there.
- A member commented that this reflects the maturation of interoperability and there are more people that want to come to the table. The types of additions that we are talking about here are important and reflect the progress that has been made.

- Steven commented that if or when the RCE bid comes to fruition the ONC may have some very strong feelings about how Carequality is governed and may have some input about what makes up the representation.
- Dave responded that there are two potential stages. There is an update to the composition because there has been a maturation of the health IT interoperability space under Carequality and might position us well for the RCE bid. If we were to win the RCE bid, there may or may not be another look at this. Maybe that the Steering Committee itself could remain at least mostly with the same composition and there could be other bodies filling some specific role and there would be more composition dictated. As we are planning, we need to have in mind that this might be a two-step process. We could add three seats without changing the dynamics of the committee. There is a chance of absence in any given meeting and that would mean having two more voices at the table. One seat for payers and two net new seats of the patient and consumer organizations.
- Steven commented that captures both the patient consumer perspective as well as the research perspective.
- Kevin asked is there any need to have an odd number of total seats versus even number in the bylaws or anything like that.
- Dave responded that there is nothing in the underlying charter or anything foundational that would mandate an odd number.
- Dave commented that as far as the large versus small providers, there is not necessarily a need to change there. We do have Tushar from eClinical Works and Geoff from GE. GE is not a small provider, but they are serving smaller practices. If the committee would like to adjust this composition, we can talk through that also.

***Action/Follow up**:* n/a

**For Reference: Current Composition (1 of 2)**

- Six (6) representatives from Carequality Founding Members
- Representatives from the following:
  – One (1) representative of federal agencies selected by the federal agencies
  – One (1) representative that can specifically represent the interests of patients
- The remaining seven (7) representatives may be drawn from members or non-members of Carequality to assure balanced representation, however:
  – At least five (5) representatives overall, potentially including those from Founding Members, must be from Carequality Implementers
  – At most five (5) representatives may be from technology vendors

***Discussion Summary:*** Dave provided the Current Composition for reference without discussion.

**For Reference: Current Composition (2 of 2)**

- The Steering Committee will, at a minimum, include at least one (1) representative from each of the following stakeholder groups below:
  – Health care provider organizations (e.g. health system, hospital, long-term care facility, etc.) or groups that represent health care provider organizations
  – Health care physician organizations (e.g. multispecialty group practice, medical groups, physician practice, etc.) or a group that represents physicians

– Health care plan or a group that represents health care plans
– State or Regional Health Information Exchanges
– Sequoia Project Board representative

- In addition to these required representatives for standard two-year terms, the Steering Committee should, to the extent possible, include a representative from at least one stakeholder group that represents a growth area or strategic opportunity, as identified by the Nominating Committee at that time.

***Discussion Summary:*** Dave commented that we have a requirement for healthcare provider organization and then healthcare physician organizations. We have more than one provider organization, but we want at least two healthcare provider organization reps and one of those two should come from a small practice.

***Questions/Discussion:*** Steven commented that in general, this is good. It makes sense to say that at least one of those would represent small practices but it may be difficult to get somebody who comes from a small practice.

- Dave agreed and commented that is why there is not as much representation. We tried before to get various stakeholder groups engaged with limited success.
- Steven suggested that he, Dave and Michael can take that offline. Physicians are not the only clinicians of importance. While we are thinking about how to juggle this to be more inclusive, we need to think beyond large healthcare systems and the physicians.
- Dave responded that there is long term care and behavioral health representation on the Advisory Council in the form of vendors that serve those spaces.
- Steven commented that AHIMA is are in their current annual elections cycle. Some of the people running are very involved in interoperability. They may have a number of leadership qualified people, some of whom won't be elected, who might want to get involved here.
- Dave agreed that getting that group worked in could be helpful.

***Action/Follow Up:*** Dave commented that he will take this discussion and formulate it into an actual straw proposal for how we would update the composition language. We have a goal that in our meeting next week we would come to a decision. If anyone has strong feelings not expressed here, please let me know offline.

## Technical Trust Policy Updates

### Technical Trust Policy – Background

- Carequality's Technical Trust Policy outlines security requirements and related policies for Carequality gateways
- In particular, the document outlines requirements around digital certificates and TLS
- The proposed changes have been reviewed with implementers, and come to the Committee with the Advisory Council's recommendation to adopt

***Discussion Summary:*** Dave commented that the Technical Trust Policy is a part of the Carequality elements. It is a peer with the query based document exchange implementation guide. The Technical Trust Policy's specific role is to outline security requirements and related policies for Carequality's gateways with a focus on the requirements around digital certificates and TLS.

- We have reviewed some proposed changes with the implementers. We are bringing the proposed changed to the committee with the Advisory Councils recommendation to adopt.
- Steve asked if there a full document or something that we can review for the stages.
- Dave responded there was a redline that came out yesterday afternoon from Chris Dickerson.

***Action/Follow up:*** n/a

**Technical Trust Policy Update – Proposed Changes**

Enhanced Flexibility in Certificate Authorities

– Ensures that going forward we can use multiple CAs for redundancy and transition purposes

– Changes to sections:

- Trust Chains (formerly, Trust Chain)
- Certificate Filtering
- [new] Multiple Trust Chain Support
- [new] Appendix

***Discussion Summary:*** Dave commented that there were changes made to give us some flexibility around the certificate authorities that are used. In practice this ensures that we can have multiple certificate authorities for redundancy and transition purposes in the future. These changes will allow us to have a backup CA established.

**Technical Trust Policy Update – Proposed Changes**

- Neutrality with Respect to eHealth Exchange
  – In preparation for eHealth Exchange becoming a Carequality Implementer, remove any special references and guidance on dual participation.
  – Changes to sections:
    - Certificate Filtering
    - [removed] eHealth Exchange and Carequality Dual Trust Domain Considerations
- Ensure Use of “Suspended” Certificate Status
  – Clarify that suspended/on hold certificates must not be trusted
  – Changes to section: Certificate Revocation and Suspended Status Checking (formerly, Revocation Checking)

***Discussion Summary:*** Dave commented that there was a section in the document that dealt specifically with considerations for those who were both eHealth Exchange and Carequality participants. Because the same underlying issuing certificate is used, but there are different attributes for the certificates and two different certs generally are used. That section is not appropriate given the eHealth Exchange migrated to be a Carequality implementer and have considerations of neutrality. It didn't make sense to have any there for eHealth Exchange, so it was removed. It is appropriate for the eHealth Exchange to provide such guidance to its participants. That would go for any other network as well. We explicitly call out the use of the suspended certificate status. This is not going to be anything that requires any changes,

because it is already built in to the underlying platform stacks that people use in practice to implement these TLS connections. But we wanted to make sure that it was explicitly called out.

***Discussion Summary:*** Leslie commented via chat that there is a clinical risk when interoperability is turned off.

- Dave responded that the suspended status is in some ways making that impact potentially lower. There have been very rare instances where a certificate has needed to be temporarily revoked. The certificate is not trusted while it is in this suspended status, but we have the ability to un-suspend without having to issue a new certificate. This would be done would be in extreme circumstances such as the potential for a gateway to have been compromised, or a certificate to have been compromised and stolen.
- Steven there was something that just happened in Singapore where we suddenly have potentially state actors getting involved in trying to get through firewalls and gain access to data.
- Dave agreed and commented security is a very serious consideration. We put a lot of thought into these changes and these are very important updates.

***Action/Follow up:*** n/a

**<u>Technical Trust Policy Update – Proposed Changes</u>**

- Update TLS Version
  – Institute a requirement for TLS version 1.2 and above, with many additional details added for clarity
  – Changes to section: TLS Cryptographic Configuration
- Miscellaneous Clarifications
  – Various clarifications that don't introduce policy changes
  – Changes to sections:
    - Certificate Filtering
    - TLS Cryptographic Configuration
    - Instructions
    - Certificate Revocation and Suspended Status Checking (formerly, Revocation Checking)

***Discussion Summary:*** Dave commented that the TLS is the most important change to the document. As the versions advance, it is necessary to evolve.

***Questions/Discussion:*** Dave commented that the updates come with the Advisory Council's recommendation to adopt. If we were to adopt these changes, there would then be an objection period by implementers and that does need to be a formal part of the process. These would officially go into effect in replacement to the current version of the Technical Trust Policy.

- Steven commented to request a motion to approve those changes to the Technical Trust Policy. Kevin made motion to approve. Seconded by Leslie. All in favor and none opposed. Motion to adopt the changes to the Technical Trust Policy has carried.
- Steven asked about what the timeline is for implementation of the new policy and does it have an applicability date built in.
- Dave responded that we will notify implementers that the objection period is starting. We have already sought feedback from implementers and it is something that we must do by

contract to provide that 30-day objection period. Then there is an additional 30-day period before it goes into effect. We will make that clear in our communication to the implementers. There could be potentially future changes where we would need to have more of a ramp up period even after they go into effect. In this case, the implementers all have the ability to support GLS 1.2. We don't anticipate there being any impact for ongoing operations from that particular aspect of the changes.

***Action/Follow Up:*** n/a

**2018 Implementer Application**

**Carequality Implementer Application Updates**

- Since 2016, Carequality has used the same application form to objectively evaluate all of our applicants.
- Feedback from perspective Implementers, legal counsel, and experience with the '16 application has informed our overhaul of the form.
- This document is integrated into our internal application review process, which also includes updates to our CC and Background Reference Call processes

***Discussion Summary:*** Chris commented that the redline version of the document that we shared is part of an overhaul of the application process. We have updated this document as well as the CC background calls and the actual organization background reference calls. All of those are in line with a new review process.

***Action/Follow Up:*** n/a

**Carequality Implementer Application Updates**

- Key updates include:
  – Additional questions about the applicant's business
- Certificate(s) of good standing
- Board of Directors member details
- Invoicing/accounting contacts
- Legal structure
  – Enhanced instructions for submitting the application to account for higher volumes
  – A more systematic approach to describing adverse security event (ASE) reporting protocols
  – Updates to information handling and data transparency that include
- New HIPAA compliance section
- Supplementary requirements for those supporting the Patient Request permitted purpose

***Discussion Summary:*** Chris commented that we wanted to get additional background about the organizations that are applying. We have enhanced instructions for submitting the application and we have seen an influx in applications. We have added instructions that make it easier to organize these applications as they come in and now have a section for adverse security reporting protocols because that is something we have to coach applicants through. We have been overhauling the information handling and data transparency section with some

additional language that we would like to see when they are giving their terms of use to their patients/users.

***Questions/Discussion:*** Dave responded that one additional element that we are asking for is proof of insurance amounts that would cover the liability limits in the CCA or reasonable evidence of revenue and reserves available that would cover that.

- Chris commented that we would like to ask for the committee's permission to start using this document.
- Dave responded that we wanted to bring this to the committee and make you all aware of it and get the approval to move forward with using the updated application.
- Kevin commented that these look like good improvements and would support this direction.
- Leslie commented via chat that there may be a difference in the insurance needed for patient apps. As a patient app who is a Carequality implementer, conceivably you could still be involved but that liability limit would still apply.
- Steve responded that assuming the app isn't hosting data, but if hosting data then we can all understand the risk. I am not sure what liability an app might have to a consumer if there were a breach, but from our perspective it is not unreasonable to ask for them to have insurance. Now we recognize that cyber insurance is expensive, although the price is coming down. As an implementer they have liability to other implementers.
- Dave commented there is no difference clause in the CCA around the liability limits for a consumer app versus any other type of implementer. It is not necessarily the liability to a consumer themselves that we are concerned about, specifically for Carequality, the primary consideration there is liability to other implementers.

***Action/Follow Up:*** Dave commented that we could take this discussion offline.

- Chris commented that there is the one issue of how it is applied to prospective implementers and what information is gathered from those that are currently implementers.
- Dave asked the committee what we do with applications currently in process.
- Steve responded that it makes sense to hold them to the new standard if we can.
- Chris responded that it would apply to Health Gorilla. The only benefit here is that most of what we have as far as changes go are additions.
- Dave responded that the more fundamental question there is likely whether the CCA itself would need to be updated. With no objections being made here, we will move forward with the new application.
- Steven asked if we hold the new applicants to a higher standard or hold the in-process applicants to a higher standard or do we go back and apply that higher standards to everybody who is already on board? If this is the right thing to do, then it is the right thing to do for everybody and need a plan to go back and rework that.
- Dave responded that there is a challenge where someone who already has achieved the implementer status.
- Steven responded that it does not seem like it is unreasonable to apply that kind of standard to our current implemented folks if it is important enough to make the change, it seems important enough to make the change across the board.

- Kevin commented that we are in agreement going forward with new requirements and that the one organization in process, this would apply to them. The question on the table is, should this apply retrospectively?
- Dave responded that it would be non-trivial but at the same time not a huge effort to go back and follow-up with all of the accepted implementers to get some of the additional information.

***Action/Follow Up:*** Dave asked Chris to pull together some numbers for the accepted applications and list what we would be asking them to implement or provide in terms of the new additions.

*Meeting was adjourned at 2:33pm EST*