Interoperability Matters
Leadership Council

10/18/2019

Leadership Council Members

Organization	Council Member	Alternate
The Badger Group	Michael Matthews – Co-chair	
American Medical Association	Michael Hodgkins – Co-chair	Matt Reid
athenahealth	Kedar Ganta	Greg Carey
Azuba	Bart Carlson	
Bay Health Medical Center	Sue Saxton	Robin Yarnell
Blue Cross Blue Shield Association	Rich Cullen	Matthew Schuller
Cerner	Hans Buitendijk	
Community Care HIE (MedWare)	Victor Vaysman	
CRISP	David Horrocks	Ryan Bramble
CommonSpirit	Sean Turner	Ryan Stewart
Delaware Health Information Network (DHIN)	Jan Lee	Randy Farmer
eClinicalWorks	Navi Gadhiok	Tushar Malhotra
eHealth Exchange	Jay Nakashima	Katie Vizenor
Ellkay LLC	Gupreet (GP) Singh	Ajay Kapare
Epic	Rob Klootwyk	Matt Becker
First Genesis	Joe Chirco	Tom Deloney
Greenway Health	Danny Shipman	
Health Gorilla	Steve Yaskin	
HealthCatalyst (formerly Medicity)	Ryan Barry	Jay Starr
HealthLX	Will Tesch	

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Leadership Council Members, cont.

Organization	Council Member	Alternate
HIMSS	Mari Greenberger	Amit Trivedi
HITRUST Alliance	Michael Parisi	Anne Kimbol
ID.me	Blake Hall	Nora Khalili
IHIE	John Kansky	
Inovalon	Eric Sullivan	
Intermountain Healthcare	Stan Huff	Sid Thornton
Jackson Community Medical Record	Julie Lowry	
Kaiser Permanente	Jamie Ferguson	Keven Isbell
Kno2	Alan Swenson	Therasa Bell
lifeIMAGE	Matthew Michela	Karan Mansukhani
MatrixCare	Doc DeVore	
Medent (Community Computer Services)	Kara Musso	
MedVirigina / Clareto	Steven Leighty	Stephen Hrinda
MiHIN	Drew Murray	Shreya Patel
MRO	David Borden	Rita Bowen
NeHII	Stefanie Fink	
NetSmart	AJ Peterson	
NextGate	Vince Vitali	
NextGen	Dan Werlin	Muhammed Chebli

Leadership Council Members, cont.

Organization	Council Member	Alternate
NYeC	Valerie Grey	Alison Birzon
OCHIN	Jennifer Stoll	Paul Matthews
OneRecord	Jennifer Blumenthal	OneRecord
Optum	Brian Lumadue	
Orion Health	Kave Henney	
PCC Pediatric EHR	Jennifer Marsala	
Safe Group	Ken Mayer	
SafetyNet Connect	Keith Matsutsuyu	
San Diego Health Connect	Nicholas Hess	Daniel Chavez
Santa Cruz HIE	Bill Beighe	
Social Security Administration	Stephen Bounds	Jude Soundararajan
Surescripts	Tara Dragert	Kathy Lewis
Stanford Health Care	Matthew Eisenberg	
TASCET	Kari Douglas	
Updox	Michael Witting	
Walgreens	Renee Smith	Bindu Joseph

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Leadership Council Members, cont.

Organization	Council Member	Alternate
WOMBA	Moti Mitteldorf	Eli Rowe
Zoll	Greg Mears	

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New Members – WELCOME!

- BayHealth Medical Center

- Delaware Health Information Network

- eHealth Exchange

- HITRUST Alliance

- ID.me

- Indiana Health Information Exchange

- NextGate Solutions

- OCHIN

- Stanford Health Care

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The Sequoia Project Team

Lindsay Austin, Troutman Sanders Strategies

Steve Gravely, Gravely Group

Shawna Hembree, Program Manager

Mark Segal, Digital Health Policy Advisors

Dawn Van Dyke, Director, Marketing Communications

Mariann Yeager, CEO

Agenda

- Review Agenda
- Information Blocking Workgroup
  - Phase II Updates [Advise]
  - New project proposal [Advise]
- TEFCA Update: RCE Updates [Inform]
- Sequoia Board Elections [Inform]
- Public Advisory Forum [Inform]
- Annual Meeting [Inform]

Information Blocking Workgroup
Phase 2

Workgroup Representatives

Associations and Orgs - health IT community
- Anne Kimbol, HITRUST Alliance
- Mari Greenberger, HIMSS
- Lauren Riplinger, AHIMA
- Scott Stuewe, DirectTrust

Consumers
- Ryan Howells, CARIN Alliance
- Deven McGraw, Ciitizen

Consultant
- Brian Ahier, MITRE Corporation

Federal Government
- Steve Bounds, SSA

Health Information Networks and Service Providers
- Angie Bass, Missouri Health Connect
- Dave Cassel, Carequality
- Laura Danielson, Indiana Health Information Exchange
- Paul Uhrig, Surescripts, Co-Chair

Healthcare Provider
- David Camitta, CommonSpirit, Co-Chair
- Eric Liederman, Kaiser Permanente
- Matt Reid, AMA
- Mari Savickis, CHIME

Legal, Technology, Standards, and Policy Subject Matter Experts
- Jodi Daniel, Crowell & Moring, LLP
- Josh Mandel, Microsoft
- Micky Tripathi, MaEHC

Payers
- Nancy Beavin, Humana
- Danielle Lloyd, AHIP
- Matthew Schuller, BCBSA

Public Health
- John Loonsk, APHL

Vendors
- Aashima Gupta, Google
- Cherie Holmes-Henry, EHRA / NEXTGEN
- Rob Klootwyk, Epic
- Josh Mast, Cerner

Informatics
- Doug Fridsma, AMIA

Safety Net Providers / Service Provider
- Jennifer Stoll, OCHIN

Release of Information Company
- Rita Bowen, MROCorp

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Information Blocking Workgroup: Purpose

- ✓ Provide input into Sequoia comments to ONC on proposed rule
- Identify practical, implementation-level implications of proposed and final information blocking rules, which may or may not be consensus positions
- Facilitate ongoing discussions to clarify information blocking policies and considerations prior to and after the Final Rule

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Information Blocking Workgroup: Agenda—Phase 2

Overall approach: Focus on implementation and compliance implications of ONC proposed rule elements and likely outcomes. Not relitigating comments.

- ✓ Meeting 1 (6/20) Review comments submitted and proposed workplan
- ❖ No July Call
- ✓ Meeting 2 (8/2) HIE/HIN and Other Key Definitions
- ✓ Joint Workgroup & Leadership Council (8/21) – In-person and virtual
- ✓ **Meeting 3 (9/13) Information Blocking Practices**
- ✓ **Meeting 4 (10/11) Recovering Costs/RAND Licensing**
- • Meeting 5 (11/8) Compliance Plans (or review Final Rule Out)
- • Deliverable: Summary of Meetings 2-5: Guidance to the Community and Implementation Feedback to ONC
- • Meeting 6 (12/13) Review Final Rule or TBD

September Topic Recap: Information Blocking Practices

Practices: Selected, Edited ONC Examples
Restrictions on Access, Exchange, or Use

- Requiring consent to exchange EHI for treatment even though not required by law
- Developer refuses to share technical information needed to export data
- HIN restriction on end-user sharing EHI with non-HIN members
- Vendor only provides EHI in PDF on termination of customer agreement
- Developer of certified health IT refuses to license interoperability elements reasonably necessary for others to develop and deploy software that works with health IT

Practices: Selected, Edited ONC Examples
Limiting or Restricting the Interoperability of Health IT

- Actor deploys technological measures that restrict ability to reverse engineer to develop means for extracting and using EHI in the technology

- Hospital directs EHR developer to configure technology so users cannot easily send electronic referrals to unaffiliated providers, even when the user knows Direct address and/or identity of the unaffiliated provider

- Developer prevents (e.g., by exorbitant fees unrelated to costs or by technology) third-party CDS app from writing EHI to EHR as requested by provider

- Provider has capability to provide same-day access to EHI but takes several days to respond

Practices: Selected, Edited ONC Examples

Impeding Innovations and Advancements in Access, Exchange, or Use or Health IT-Enabled Care Delivery

- Developer of certified health IT requires third-party apps to be "vetted" for security but does not vet promptly

- Developer of certified health IT refuses to license interoperability elements that other applications require to access, exchange, and use EHI in the developer's technology

- Provider engages integrator to develop interface engine but its license with EHR developer prohibits it from disclosing technical documentation integrator needs to perform the work [without broad non-compete]

- Health system insists local physicians adopt its EHR platform, which provides limited connectivity with competing hospitals and threatens to revoke admitting privileges for physicians that do not comply

- HIN charges additional fees, requires more stringent testing or certification requirements, or imposes additional terms for participants that are competitors, are potential competitors, or may use EHI obtained via the HIN in a way that facilitates competition with the HIN

Practices: ONC Examples
Rent-Seeking and Other Opportunistic Pricing Practices

- Developer of certified health IT charges customers a fee exceeding their costs for interfaces, connections, data export, data conversion or migration, other interoperability services

- Developer of certified health IT charges more to export or use EHI in certain competitive situations or purposes

- Developer of certified health IT interposes itself between customer and third-party developer, insisting that developer pay licensing fee, royalty, or other payment [not related to costs] for permission to access EHR or documentation

- Analytics company provides services to customers of developer of certified health IT and developer insists on revenue sharing that exceeds its reasonable costs

Practices: ONC Examples
Non-Standard Implementation Practices

- Actor chooses not to adopt, or to materially deviate from, relevant standards, implementation specifications, and certification criteria adopted by the Secretary

- Even where no federally adopted or identified standard exists, if a particular implementation approach has been broadly adopted in a relevant industry segment, deviations from that approach would be suspect unless strictly necessary to achieve substantial efficiencies.

- Developer of certified health IT implements C-CDA for TOC summary receipt but only sends summaries in a proprietary or outmoded format

- Developer of certified health IT adheres to "required" portions of widely adopted standard but implements proprietary approaches for "optional" parts of the standard when other interoperable means are available

Implementation and Compliance Implications and Needs
Are the ONC examples unambiguous and sufficiently specific?

- Examples generally reasonable given underlying statutory and regulatory definitions of information blocking, recognizing areas of ambiguity

- In many ways, examples appear to be catalog of complaints to ONC from stakeholders and can be understood as high priority concerns that will/should motivate enforcement and compliance; there are, however, specific issues per the below points:

  - Recognize/clarify that definition of *Electronic Health Information* (EHI), central to these practices, is not limited to information used for treatment

  - "Promptness" (e.g., for security vetting) is subjective and subject to fact situations

    - General concern if term in a practice example, like "promptness", does not have a corresponding reference in an exception

  - Another issue relates to ONC practice example for information release, when a provider has capability to do same-day release but takes several days

    - Such a delay could be reasonable, for example if provider must deal with flawed authorization form, missing key elements in release or a bad signature

    - Technical and even process capability may not offset situational specifics

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Implementation and Compliance Implications and Needs:
Do you disagree with any of ONCs identified practices?

- Need clarification on whether state or local government would be *Actors (e.g.,* an HIE or HIN), and subject to enforcement
  - If so, several practices would be problematic for government public health agencies
- References to "optional" vs. "required" aspects of standards examples do not align well with how optionality viewed in implementation guides or world of implementers; for example, "optional" generally viewed as <u>optional</u>.
  - Implementation guides usually specific to use case(s)
  - What if optional extension not used exactly as described in the standard or the required part of the standard is not used exactly as prescribed
  - General point: examples and enforcement need more nuanced view of how standards are implemented
- With respect to "[h]ealth system policy requiring consent to exchange EHI for treatment even though not required by law," workgroup members emphasized that multiple federal and state laws at play and important for OIG and ONC to coordinate with SAMSHA (42 CFR Part 2) and state agencies to reduce confusion on how to interpret and harmonize non-HIPAA privacy regulations, which could affect information blocking
  - Is failure of EHR to segregate Part 2 data, which could hinder interoperability (e.g., all data for a patient excluded from exchange), information blocking?
  - Decisions on whether to segment at record or data element level could affect ability to exchange data

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Implementation and Compliance Implications and Needs:
Do you disagree with any of ONCs identified practices?

- In addition, a vendor may build a capability that a client (e.g., provider or HIE/HIN) chooses to not acquire or implement (e.g., data segmentation)
  - Is provider decision not to acquire or use a capability information blocking, especially when there are cost and ROI considerations for deploying specific capabilities (e.g., the cost to a provider to implement data tagging and segmentation)?

- What is a vendor's obligation to develop and offer capabilities that could enhance interoperability, especially with respect to supporting certain regulatory requirements?

- Important to recognize a provider's conservative approach to HIPAA compliance may be well within accepted legal and compliance approaches, especially given concerns with OCR enforcement of HIPAA requirements
  - How will OCR compliance concerns be balanced with OIG/ONC compliance concerns?

- Was a sense (and a concern by some) that Cures and information blocking regulations will eliminate any "wiggle room" in implementation of HIPAA and 42 CFR Part 2 and other privacy and security regulations, some of which have conflicting imperatives (e.g., protect information vs. release information)

Implementation and Compliance Implications and Needs:

Are there examples where "likely" standard especially problematic?

- Concern when "likely" standard in ONC information blocking definition paired with "knowledge" standards, which are applied differently by type of actor
  - Challenging for HIE (as intermediary) to know which "likely" interpretation to follow; their own or members', which may have different preferences and policies
- HIPAA sometimes authorizes release of information outside of Treatment, Payment or Operations, such as for research via an Institutional Review Board (IRB)
  - Can an outside organization cite its *own IRB* as a rationale to demand exchange?
- "Likely" already coming into play
  - Some companies are demanding immediate information release based on what responding provider views as deficient authorization forms
  - At what point does vetting equal information blocking, especially given "likely" standard?
  - From Release of Information Vendor perspective, there are times when bad actors submit authorizations for release

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Implementation and Compliance Implications and Needs:
Are needed examples missing?

- Vendors charging providers for development or implementation of data segmentation capabilities or other regulatory support

- More definition needed re: "reasonable" costs/fees

- Need examples of "without special effort" and for actor use of third-party developers that may have "all or nothing" consent policies

- Need examples that address *writing* to an EHR as "use"
  - Writing much more complex than read access, from a technical, operational and health information management (HIM) perspective
  - Latter issue goes to important role of the HIM function in validating information entered into medical record (e.g., via app or HIE)

- Is an unreadable C-CDA information blocking and what makes a C-CDA unreadable, the vendor implementation or the sending organization's documentation practices?

- General recognition/concern that information blocking will be "weaponized" via private party negotiations, creating de facto, but <u>private sector,</u> enforcement

- With these and similar examples, ONC and OIG would have extreme discretion on practices to deem information blocking and select for enforcement

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October Topic Recap: Recovering Costs/RAND Licensing

Exception: Recovering Costs Reasonably Incurred

- Actor may recover costs it reasonably incurs, in providing access, exchange, or use of EHI

- Fees must be:
  - charged on basis of *objective and verifiable criteria uniformly applied* to all similarly situated persons and requests;
  - *related to the costs* of providing access, exchange, or use; and
  - *reasonably allocated among all customers* that use the product/service

- Fees must not be based:
  - in any part on whether requestor is a *competitor*, potential competitor, or will be using EHI to facilitate competition with the actor;
  - on *sales, profit, revenue*, or other value that the requestor derives or may derive *that exceed the actor's reasonable costs; or*
  - *anti-competitive* or other impermissible criteria

- Certain costs excluded from this exception, such as costs that are *speculative or subjective* or *associated with electronic access by an individual to their EHI*

Issues: Documentation? "Related" to costs vs. equal to costs? Profit – not in regulatory language? Unintended consequences?

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Exception: Licensing Interoperability Elements on Reasonable and Non-Discriminatory Terms

- Actor that controls technologies or other interoperability elements that are necessary to enable access to EHI will not be information blocking so long as it licenses such elements on *reasonable and non-discriminatory terms (RAND)*

  - RAND terms often used by SDOs

- License can impose *reasonable royalty* but *must include appropriate rights* so licensee can develop, market, and/or enable use of interoperable products and services

- License terms must be based on *objective and verifiable criteria* that are *uniformly applied and must not be based on impermissible criteria*, such as whether the requestor is a potential competitor

Issues: Documentation? Unintended consequences? "Reasonable"? Scope of this requirement – EHRs?

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Implementation and Compliance Implications and Needs
Likely additional documentation burdens for cost-based pricing

- This approach to pricing would be major departure from current practice

- General concern: could be a burden and have a chilling effect on development, especially for developers and HIEs
  - But likely not for providers or others do not charge for information release

- Level of burden driven in part by extent of "interoperability elements" subject that are ultimately found subject to information blocking in ONC final rule and needing exception (e.g., API used for data access vs. entire EHR)

- Uncertain on accounting granularity needed: more granular = greater burden

- Pricing and accounting under review by organizations given proposed rule

- Required detailed cost accounting could reduce services from developers, etc.

- Uncertainty/concern whether and at what level costs would need to be disclosed to/auditable by regulators and especially data requesters

- "Reasonableness" will depend on facts and circumstances per ONC - who needs to be convinced pricing is reasonable and what documentation needed?

Implementation and Compliance Implications and Needs
Likely additional documentation burdens for cost-based pricing

- May need detailed information on customers and their competitors to ground cost/price documentation in factors like "similarly situated," (e.g., bed size data)

- Will be very challenging to be consistent across all "similarly situated" clients given variability of circumstances, especially for development and implementation costs

- Cost data are proprietary and unclear how this exception addresses that issue

- Anti-trust issues for cost disclosure to competitors (e.g., issue of input price disclosure – see https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/dealings-competitors/price-fixing)

- How often will pricing need to be revised as costs are recovered over time?

- How long should cost recovery take, especially as customers leave and arrive and products/services are updated – issue of dynamic vs. static cost structure?

- Need to address cost recovery for non-standard development and implementation, which will be unavoidable in many cases (and need clarity on what costs for "non-standard" implementations are defined/recoverable)

- To avoid unintended consequences, ONC should consider higher-level approach focusing on non-discriminatory, transparent and consistent pricing (allowing "apples to apples" comparisons), without need for detailed cost accounting. Cures would permit such an approach as HHS has wide discretion on exceptions (recognizing pricing concerns were major driver for underlying Cures provisions)

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Implementation and Compliance Implications and Needs:
Terms likely to be most problematic (e.g. "reasonable)

- Need very clear definition of terms, especially "reasonable" costs

- Ambiguity around key terms, and broader pricing-related exception issues, could have a chilling effect to business entry and conduct

- Higher-level focus on pricing transparency can offset need for terms needed for detailed cost accounting approach

Implementation and Compliance Implications and Needs:
Issues with cost allocation across customers

- Cost allocation across customers will very challenging and need to account for allocation and reflect in prices could radically alter business practices

- Impossible for developers to know which customers will want technology under development when pricing determined as part of go-to-market plan

- Should costs only be allocated over actual customers or over the potential, applicable customer base?

- If development for one client, but potentially applicable for others, need way to price that does not penalize this one client or lead to unsustainable pricing given market dynamics (are cross-subsides prohibited?)

- Again, a higher-level focus on non-discrimination could obviate the need for detailed cost allocation

Implementation and Compliance Implications and Needs:
Pricing based on customer size as preferred approach

- Non-profit pricing partially grounded in expected costs but also reflects need to be able to invest in future projects

- Pricing based on customer/member size (e.g., revenue, employees, number of beds, etc.) common for non-profits (e.g., industry collaboratives and HIEs)

- Customer size can be reasonable proxy for level of support effort an organization will require

- Pricing by customer size can reflect concern with fairness/ability to pay

- Non-profits would need to invest in more detailed cost and market analyses to rigorously assess role of size as cost proxy and fairness issues

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Implementation and Compliance Implications and Needs:
Familiarity with RAND licensing

- Very low familiarity with RAND licensing among workgroup members and this lack of familiarity likely widespread across community of actors

- While often used by Standards Development Organizations which incorporate the intellectual property of third parties into the standard, it is not clear that RAND is a good fit for terms of licenses to software that developers are selling to customers in a commercial marketplace

Implementation and Compliance Implications and Needs:
Software typically sold via a license that could be subject to RAND

- Much health IT software sold via a new or existing license

- Compliance will likely increase costs of doing business

- Regulators and actors will need clarity on when cost vs. RAND exception apply and whether any opportunity for strategic choice to rely on one or the other

- Unclear if intent is specific IP (e.g., a code set, patent, or proprietary API) or broader access to all IP associated with interoperability elements in any way

- Great need for clarity on scope of the interoperability elements (e.g., API or interface vs entire EHR) to which exception relevant

- Need to respond to licensing requests in 10 business days will be challenge (similar to need for timely response for "infeasible requests" exception)

- Organizations that primarily license IP could face major business model challenges, with need for non-discrimination conflicting with complex licensing scenarios

- Patent infringement subject to treble damages, reinforcing complexity of IP licensing

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Implementation and Compliance Implications and Needs:
How long will it take to review/revise pricing and licensing?

- For both pricing and contracting, key issue is when liability for information blocking in context of finalized exceptions begins – effective date of final rule or will there be a grace period or "learning year"?

- Time needed for review will depend on scope of interoperability elements subject to exceptions – three (3) months is best case even if very narrowly defined but more likely will be a year or more for contract and price review and revision

- If must revisit all agreements and pricing, will be very complex and time consuming – there will be an initial period and additional ongoing review for new *and* existing contracts and prices

- For contracting and infeasible exceptions, need processes to review "timely" or within 10 business days as applicable

- Requests for EHI/interoperability element may come from many "actors" not specified in the final rule and in unanticipated forms and channels

- More generally, need to establish and document processes for timely handling

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Interoperability Matters Priorities

Recommendation: Data Quality Project

- Polled members and discussed at 8/21 in person Leadership Council Meeting
- Universal agreement regarding need to improve data quality
  - Transport agnostic
  - Build upon USCDI, but focus on end user data needs
  - Leverage joint Carequality-CommonWell work effort
  - Explore launch of new Interoperability Matters project
- Considerations
  - Resources primarily focused on existing priorities (i.e. Information Blocking and RCE)
  - Would require new resources
  - Explore strategy for project co-sponsors

ONC Designated Recognized Coordinating Entity (RCE) Update

Framework Agreement Flow-Down
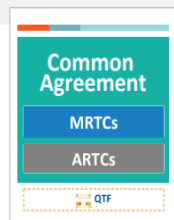
Common Agreement

The parties to the Common Agreement will be the RCE and one or more QHINs. The Common Agreement will include flow down clauses for the QHIN's agreements with its Participants and the Participant's agreements with its Participant Members.
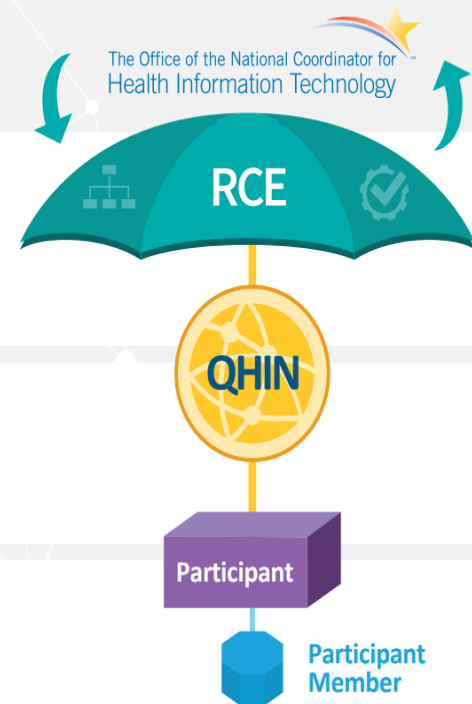
Participant-QHIN Agreement

An agreement between a Participant and a QHIN.

Participant Member Agreement

An agreement between a Participant and a Participant Member.

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Key RCE Activities

- Work in close collaboration with ONC and stakeholders to:
  - Engage stakeholders through virtual listening sessions
  - Develop and maintain the Common Agreement (with ONC final approval)
  - Develop and maintain the QHIN Technical Framework (QTF) (with ONC final approval)
  - Designate and monitor Qualified Health Information Networks (QHIN)
  - Implement ONC-approved process to adjudicate QHIN noncompliance with CA
  - Propose sustainability strategies

RCE Milestones

Milestone	Activity	Year
Milestone 0	Program Planning and Evaluation – [IN PROCESS]	Year 1 only
Milestone 1	Develop Common Agreement for ONC approval and publication on HealthIT.gov and in Federal Register	Year 1 only
Milestone 2	Convene virtual public listening sessions	Years 1-4
Milestone 3	Designate and Monitor QHINs	Years 2-4
Milestone 4	QHIN Monitoring and Compliance Enforcement	Years 2-4
Milestone 5	Update the Common Agreement	Years 2-4
Milestone 6	Develop QHIN Technical Framework (v1) and Update	Years 1-4
Milestone 7	Propose RCE sustainability strategies	Years 3-4

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Principle Activities for Year 1 (8/29/19 - 8/28/20)

- Develop Common Agreement
  - Minimum Required Terms and Conditions (MRTCs) – ONC developed
  - Additional Required Terms and Conditions (ARTCs) – RCE developed
- Develop QHIN Technical Framework – RCE developed
- Stakeholder Engagement and Input – RCE and ONC facilitated

  Examples of RCE convening methods
  - Listening sessions indicate a method for stakeholder input
  - Work group(s) as other means of getting input as long as inclusive
  - Stakeholder sessions (e.g. in person meetings at HIMSS conference)
  - Sequoia annual in person meeting, followed by public call

Status Update

- Completed
  - Grant awarded 8/29/19
  - Announced 9/3/19
  - Kickoff meeting 9/11/19
  - Baseline plan developed
  - RCE web site launched
- Work in Process
  - Minimum Required Terms and Conditions (MRTC) review calls
  - Stakeholder engagement strategy
- Next Steps
  - Stakeholder engagement plan details
  - Outline Additional Required Terms and Conditions topics
  - QHIN Technical Framework

Sequoia Board Elections

Context for Board Transition and Elections

- Sequoia board oversaw restructure and continued for one year transition period Oct 2018-Oct 2019

- Elections now required to fill all Sequoia board seats according to current size and composition requirements

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Sequoia Board Size

- 13 voting directors elected by Sequoia Members

- Up to 4 voting at-large directors selected by the sitting board

- Unlimited number of government liaisons

- Unlimited number of non-voting directors who have specialized expertise or experience

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Sequoia Board Composition (Minimum and Maximum)

Stakeholder Perspectives	Minimum	Maximum
Provider organizations / clinicians across the continuum [1]	1	4
Health information networks (HINs) [2]	1	3
Vendors	1	3
Health Plans	1	2
Consumers	2	2
Standards Development Organizations (SDOs) / accelerator projects	1	2
Governmental liaisons [3]	Not specified	Unlimited

[1] or   Healthcare provider organizations and/or an organization or individual who represents the interests of physicians or other clinicians (e.g. health systems, clinics, physician practices, pharmacies, other care settings, physicians, other clinicians)

[2]   HINS (e.g. national networks, regional/state HIEs, other types of HINs)

[3]   Expand governmental liaisons to also include representatives from NIST, CMS and ASPR.

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Sequoia Board Election Process

- All board members up for re-election / appointment
- Nominating Committee required to oversee nomination and election process
- Proposed steps and timeframes
  - October 2019: Nomination Committee formed; call for nominees
  - November 2019: Nominations submitted
  - December 2019: Election of new Board members
  - January 2020: Onboard new Board members; officer elections

- Guidance:
  - No crossover representation with eHealth Exchange or Carequality boards
  - Consideration of RCE role (e.g. optics, strategic oversight of grant and stakeholder engagement)

Upcoming Events

Interoperability Matters Public Advisory Forum

- Next call: Friday, November 1th, 1:00 – 2:00 pm ET

- Agenda:

  - Information Blocking Workgroup Update

  - Discussion of ONC's Trusted Exchange Framework and Common Agreement (TEFCA)

  The Public is invited to register to attend this virtual meeting:
  https://register.gotowebinar.com/register/5962237443742749196

Registration Now Open!

The Sequoia Project's Annual Member Meeting will feature discussions of ONC's Trusted Exchange Framework and Common Agreement, health IT disaster response planning, innovations in patient identity management, clinical content quality and accuracy, and more. The meeting will provide an opportunity to connect with senior leadership, members, and government officials while addressing key health information sharing issues.

https://sequoiaproject.org/events/annual-meeting-19/

Interoperability Matters

https://sequoiaproject.org/interoperability-matters/