



HIT Policy Committee Consumer Workgroup Final Transcript May 6, 2015

Presentation

Operator

All lines are now bridged.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Consumer Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded.

Also as a reminder, for those that are following along via the webinar and who use the public comment chat please be advised that we may share those public comments during the public comment period at the end of the meeting and with that I'll now take roll. Christine Bechtel?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Christine. Amy Berman? Brad Hesse? Clarke Ross?

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

Good afternoon.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Clarke. Cynthia Baur? Dana Alexander? Danielle Tarino? Erin Makay?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

MacKay, I'm sorry.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Oh, no worries, thank you, here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi. Ivor Horn? Kim Schofield?

Kim J. Schofield – Advocacy Chair – Lupus Foundation of America

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Kim. Leslie Kelly Hall? Luis Belen? MaryAnne Sterling?

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, MaryAnne. Nick Terry?

Nicolas P. Terry, LL.M. – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Nick. Phil Marshall?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Wide awake on the west coast.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Teresa Zayas Caban? Theresa Hancock? Wally Patawaran, I'm sorry, Wally?

Wally Patawaran, MPH – Program Officer – The John A. Hartford Foundation

Hello...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hello. Wendy Nilsen? Will Rice? And from ONC do we have Chitra Mohla?

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Chitra. With that I'll turn it back to you Christine.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great, well thanks everybody for joining us. What we want to do today is work towards finalizing comments on objective five and six. So the schedule going forward is that tomorrow I have about 30 minutes to present to the Advanced Health Models Group which is formerly the Meaningful Use Workgroup and they're hearing from lots of different Workgroups to try to streamline comments that will go before the Policy Committee next week. So that's tomorrow.

And then we've got one more call, if we need it, on Monday, May 11th, that is the day before the Policy Committee where I will present in person on Tuesday. So, that's the schedule. So, we'll see how far we can get today.

You guys all have in your e-mail the document that we're going to be looking at, it's a Word document that's called MU 3 comments compiled. Is it possible for...yes, see you guys knew where I was going. So, all right, so you can see what it looks like on line. I'm going to...so we'll leave the screen up as it is and we'll just start to go through the comments.

I have received comments from a couple of individuals and we can talk about those and I will circle back for folks that weren't able to make the call. So, any questions before we dive in?

Okay, so what I'd like to do is kind of take this thing section by section and talk through the comments so you can see how we structured this is basically to start with objective five, measure one and just say, yes we support these things, you know, great in concept. We then, per our previous meetings, have agreed with the proposal to provide 80% of patients the ability to view, download or transmit within 24 hours.

I noted the comments about folks saying, you know, some of our Workgroup members saying it should be real-time so 24 hours though is what the Workgroup agreed to and that we really should do more than kind of turning on the function. So, I'm going to ask for comments on those two things.

I would like to reserve the right to look at the attestation process for Stage 2 because I think it actually does require for the offer, I believe it does require the act of communication to patients, so we may not need to make that comment if that is required.

But any comments or changes to those first two concepts that I've just outlined which are bullets one and two in the document on page one?

Okay, great, so where I think we need to focus for the next little bit is on the API piece. So, you guys have basically seen...what the Workgroup has recommended is a “both option” that providers be required to implement both the API approach as well as the view, download, transmit that’s what we’ve been discussing and the reason...so I want to say that, Phil, I’m going to kind of preview your comment, at a general level these comments do have a slightly skeptical tone to them and I think that’s reflective of the Workgroup but it may just be reflective of my thinking so I want to check in with you guys about this.

But there are basically two reasons for the concern, one is that the API, as you know, would only be certified for the download function and so if you allow providers to only do API then you would realistically...consumers could lose a lot of functionality in the marketplace because they would be downloading their information into a third-party application and that third-party application is, in all likelihood, not going to really be facilitating communication back to the care team at your primary care practice, at least it’s not certified to do that, and if it isn’t certified to do those things...well that opens up just an awful host of issues and so the concern about not losing functionality is concern number one or one of the two.

The second concern, and this for me personally is a far larger concern, is the privacy and security component. So, we do talk about those in here but essentially the rest of the comments that are in the 4th, 5th and 6th bullets essentially talk about the functionality and whether they should add more to a certification, and they also begin to mention privacy and security.

So, I’m going to tell you what the concerns are in privacy and security that we’ve talked about, I don’t know if Nick has been able to join this call or not, I know that he was out of the country.

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

I’m here.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, awesome. So, I think the concern with APIs that we’ve been discussing is that you cannot...the third-party entities where you would download your data are not covered entities under HIPAA. There really is no robust regulatory framework and so the concern is that even the proposal this Workgroup has made, which is both VDT and API, could explode the market for selling data and to do so in a way that is very difficult because there isn’t a strong legal framework to control or influence. And so that is I think really the concern that I want to also talk about today. So, I’ll stop there and let folks respond.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Christine, this is Erin, I read the comments as more appropriately cautious than skeptical. I think given the potential impact that these changes could have on the way that patients and families access their information and potentially do a lot of other things with their digital healthcare I thought that the comments struck a necessary balance. But that’s just my two cents.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Others?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah, it's Phil, so the concern I have in...so the Consumer Workgroup representing these privacy and security concerns is really...one is, the privacy and security concerns are really no different than a person downloading their data through VDT to a device of their choice and so expressing concern about how the person might use an application or to what application a person might download this data to would be akin to really being concerned about the security of a computer that the patient might be using which, you know, is really not something that has panned out to be a real concern, because, patients, you know, need to be able to choose to take that risk and so obviously with the right amount of understanding.

I think it's fine, frankly, to express the need for electronic health record systems under their terms of use to be clear about, you know, risks to health data or, you know, applications, you know, under FTC guidance will need to be clear and accurate about all of that as well, but as you know, Christine, I'm in favor of a very enthusiastic support of the API for everyone being available in the broad marketplace for consumers to be able to break out of the silos.

And so I'm just not...I'm not comfortable with a lot of privacy and security concerns being expressed from the consumer perspective knowing that there is another Workgroup that is looking closely at that, but, you know, I've...that's really kind of the reason that I expressed that point to you earlier.

Nicolas P. Terry, LL.M. – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

So, this is Nick, I guess not surprisingly I would tend to go the other way. I think that it is vitally important that this group with its consumer voice state some real concerns about what could happen about the failure so far for any branch of the federal government, any agency to come up with a coherent protection model for medical data that is now going to be swimming outside of the HIPAA protected space.

And I think to your specific points the average consumer, one assumes, has relatively little sense about either the law or the technology with regard to privacy and security here, but what every patient is absolutely sure of, because the moment they walk into any healthcare entity, they are deluged with privacy notices and information about how their data is being protected and I think it is quite a stretch to believe that consumers would then think that "oh, well, but if download this or I use it on an App then all of that stuff that I've been told about in HIPAA wouldn't apply" it would make it...it makes no sense to me as a lawyer so I don't see why it should make sense to an average user.

The second point and it is a broader point, if we want markets to operate there has to be relatively sort of clear governance and clear regulation that doesn't...that's not an excuse for over regulation, it's clarity. Tech companies don't like indeterminacy if there are rules of the road whereby we consumers voice the demand for the protection of their medical data, even outside of conventional healthcare, then I think that will help the market solutions that we all want to flourish.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, I was going to...

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Well, I would just respond that I think any attempt to regulate the application marketplace would be...would end up being anti-consumer and I think that in the end, at least what I've observed over the last 20 years, in the attempt to sort of protect consumers "from themselves" so that they don't do bad things or they don't take risk really has never...it has really never proven helpful or useful.

I just...I'm really speaking more from the Consumer Workgroup as opposed to the Privacy and Security Workgroup that this framework for the first time frankly really breaks out of the EHR silos and gives consumers the ability to access their data ubiquitously and systematically across the continuum and while, you know, I suppose the group could certainly represent, you know, points of caution, things to think about, I just would like to see, you know, the consumer sort of have what I consider to be an enormous opportunity and enthusiasm for it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, okay, let me try to thread this needle a little bit here. I think Phil we...I don't think Nick is suggesting nor is this Workgroup saying that we want to regulate the application marketplace as whole. There are a lot more business rules that would apply in a regulatory framework.

I think what we are saying here or at least what I'm hearing Nick say is that there is...and what we as a Workgroup have said previously as well, which is there are real privacy concerns because it's not intuitive to consumers that they just put their health information that five seconds ago was literally governed by HIPAA when they moved it to this other place on their own computer it's not anymore and in fact the holder of that data can sell it, can claim ownership over it, can do all kinds of stuff that as long as they put in their terms of use. So, they can be transparent, to your point, about their terms of use but their terms of use might be really bad practices that open consumers up to all kinds of problems.

So, here's the...so let me, I want to say one thing and then make a possible suggestion here. It is, Phil to your point about the Consumer Workgroup wading into privacy, it is absolutely in our scope if there is some major policy issue that we think impacts consumers then we really do have the responsibility to raise that, but I also recognize that we're not deep with privacy experts on this group.

So, what we might do here is I think kind of caveat our comments to say, look API is a technically brilliant solution to, as you say Phil, ending the silos in healthcare, but there is one very large policy problem with that and that we asked the Privacy and Security Tiger Team to show us and I think we've sent the previous letter out from the Tiger Team it's now a full Workgroup that we sent that out and the material for this call.

So, maybe we say, we do need some assurance from the Privacy and Security Group about what could happen in this marketplace, what the legal rights and ramifications are or aren't before this group is comfortable really weighing in 1000% for APIs. That would be an approach that I would be comfortable with because I really don't want this Workgroup to be in a position of saying, look technically this is a great solution and we just created a market where...here's what my concern and I think what I hear Nick say and others in the past have said, vendors today sneak in all kinds of crazy practices about data, so you know this better than anybody we've talked about this, you know, so they'll say, well I have exclusive ownership of the data in your EHR just by virtue of the fact that you're using my EHR. They do that with providers and people who have big deep privacy, security and IT departments.

I think what the...I worry that there is a potential to do some really crazy things to consumers that we haven't anticipated or thought about with respect to selling their data. I don't know about their rights to sell identifiable health information and we frankly lack a privacy protective, you know, framework in this country for that unless you're a covered entity under HIPAA.

So, my suggestion would be that we appropriately outline these concerns but equally say the technology is awesome and it would go a long way and we can strengthen the description of the benefits of APIs but we need to hear from the Privacy and Security Workgroup with respect to their thinking on this...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Christine, this is Erin...

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah, the only thing I would add...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Go ahead.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Oh, no, Erin, I've talked too much so you go.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Oh, okay, well I was just going to say I think that's a good suggestion Christine. I think it is absolutely appropriate for this group to be raising questions like this. I think we are still in the midst of a national sort of transformation towards health information technology, we're not there yet and we don't want concerns from patients to hinder our continued progress.

The National Partnership has survey data indicating that patients say that it's important to them to know how their information is being collected and used but that, you know, for the majority of them their doctors aren't doing a good job explaining what's happening to their information and that's for information that is, you know, in an electronic health record protected by HIPAA because it's in a covered entity.

So, I like the suggestion of referring it out the Privacy and Security Team but I do think this is a critically important issue and one that could potentially, regardless of how amazingly technically awesome APIs are, you know, if there is an incident and, you know, I'm thinking consumers see every day about another breach of health records from a covered entity and I don't want...I think we need to be really cautious and careful that yes this is a great direction to be moving, you know, we want to be moving in this direction but there are serious questions that we have, questions and concerns, and again I think it's appropriate for this group to raise those.

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

And this is MaryAnne and I wanted to add one of my concerns as well if I could. So, for me this comes down to something perhaps a little more basic and that is, you know, for the last several weeks on this call we have all had the benefit of having experts on APIs on the call with us that we could ask copious amounts of questions and get great answers. You average small doctor practice doesn't have that advantage, they don't have an IT department, they don't have experts on APIs to whom they can pose questions.

And I would venture to say that my doctor's office probably doesn't have any idea what an API is. So, I have more basic concerns that, you know, sort of bubble up to the level that you guys are talking about now about privacy and security because if these providers don't have a basic or perhaps an advanced understanding of APIs and how to use them we could get into even more trouble if that makes sense.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, thanks, MaryAnne.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

This is Clarke Ross I wanted to reinforce MaryAnne's point. In our roadmap comments we emphasized the importance of an affirmative education of both providers and consumers and so I think we should reinforce that need here.

Two, if we're listing potential misuse the major problem people with disabilities and mental illness face is sharing data with their employers and suffering the consequences and discriminatory consequences which is protected in the American's with Disabilities Act, but an unknown arena of sharing is problematic for everybody legally and ethically, and so if we want to develop some examples of areas that need boundaries I would like to see sharing with employers on that list.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, I think, Clarke, that's the issue that I'm kind of raising which is there is no law, that I'm aware of, that would prevent a third-party application from sharing data with an employer. So, this is the privacy and security concerns that I think we just need the experts to tell us, are we right or wrong about this.

I mean...I don't know if they can share identifiable data with my employer or if they can come in and say, I now own your health information and anything you put in here, you know, they own somehow and can do whatever they want. So, I don't know the answers but I just think we need those.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

Right...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, I mean...

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

And I'm comfortable with your proposal I just thought maybe a few examples of our concerns would put the context of your proposal.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Got it, perfect, thank you.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

And Christine maybe on the side of that recommendations to the Tiger Team maybe you could also recognize that, you know, we do recognize that other industries like the financial industry have successfully deployed, you know, APIs for consumers ubiquitously and so maybe recognizing that, you know, there may be some, you know, standards and guidance and experience that's been gained from those other industries that could guide us as well.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I think that's a fair point and we could ask the Privacy and Security Workgroup, you know, look we understand these things as well but, you know, and the banking industry, you know, what...I think they did have, if I recall correctly, they had kind of an agreement around governance and the way that they would use that health information because there have been a lot of hearings that I think have brought in both the banking and the credit card industry. So, we'll have to look back and see what they said as well. Does that make sense Phil?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah, yeah it's just that the other industries, you know, have gained more than a decade of experience with the APIs and so there is probably a lot to be gleaned there on, you know, how well terms and conditions governed under FTC, you know, guidelines, you know, are managed and, you know, what have been the biggest, you know, issues there.

I mean all of the breaches in the financial industry that I can think of, you know, Target, Home Depot, etcetera have been as a result of hacking the database credentials...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Not individual person's credentials. And remember it's the individual person's credentials that are proposed to be the gateway for any access to the health APIs. So, anyway, yeah, the other industry experience...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Might be helpful here.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, I do want to just raise one thing because I was thinking about...so there is a proposal in the certification rule to request comment about other requirements that might be needed to foster open APIs.

So, the first thing is I think we probably need to strengthen these comments, and if the folks running the website could maybe go to page 2 because that's kind of where we are now, I think we do need to have a stronger or a clearer statement that says that the APIs need to be public APIs. So, they can't be proprietary so that...you know we had some language about, you know, not creating kind of silo'd applications in the same way we have silo'd portals. So, one, any objection to doing that, to strengthening that comment?

Okay and then the second...so the rule, the certification rule goes on to ask should there be any limits expressed on what can be included in the terms of use, should the terms be required to more granularly address security and authorization requirements?

I'm not sure I know the answer to those things as a technical matter, but from a policy perspective and I want to, you know, ask you guys to weigh in, I'm not...relying on the terms of use to me feels risky because you can...everybody knows, right, you always are clicking a box and reading some 58 page privacy policy that is written by lawyers and you've just...it's going to take you three days to read it all, so you click the box and you agree. So, you can be transparent about your terms of use but your terms of use can also say we're going to sell your data or we own your data.

So, how...am I correct in my interpretation that we can't really use the terms of use except to say they should be transparent but they're not a policy mechanism. In other words could you use the terms of use to say, look if you are an ONC certified API your terms of use must agree that you will never sell identifiable data and that you will agree to, you know, I'm just going to throw it out, that you will agree to the same terms that covered entities are under HIPAA. So, you can't sell de-identified and you can't...or at least you have to do this certain way, you know, all of the things from HIPAA. Could you do that through terms of use? I don't think so but I want to ask.

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

Well, I guess, this is Nick, Christine I guess you're moving into BAA's aren't you? I mean, that would be a...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes.

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

Business Associate Agreement on the way there which would be an interesting way of doing it. But as you note and others have noted these are complex questions that we're flagging not trying to solve.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah, to your point Christine this actually throws it into a wholly different realm in HIPAA. I mean, HIPAA is to make sure that covered entities are treating data appropriately and so, you know, not consumers throws it into a whole different realm.

I'll give you an example, so there are hundreds of thousands of people who use PatientsLikeMe every month, the terms of use are very clear up front that this data is going to be sold to pharmaceutical manufacturers to help with the development of new drugs and therapies and people know that up front, it's actually pretty clear on their side not hidden.

And so if people want to support research and they know that the App that they're putting their credentials into are going to sell that to pharmaceutical companies it's their data. There is no difference than VDT here.

And so I would say that it really kind of does come down to the terms of use of whatever service or application that the patient has chosen to use and put their own credentials into and I would also bring up the fact that technically when an application has those credentials and it gets that data from the API that there is not a good or easy mechanism for the EHR and the API to enforce any sort of login or rather any sort of opt in the application itself and so again it just relies on those credentials having been properly put in, but again it's all, as I understand it, really now all under the FTC domain and other non-HIPAA domains.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, thanks, Phil, I did want to clarify one thing in case I'm wrong, but you had said earlier and you repeated it just now, that, you know, it's no different APIs versus VDT can still download into a third-party App. When I asked that question of our experts what they told us...we meant for this in Stage 2 what happened they said there was never a technical way to do it.

So, technically VDT right now is like V and maybe D but it's not...it really doesn't have the transmit to a third-party application technically under Stage 2. So, VDT is basically, as I understood it from the experts, essentially today means a portal period, but they...I don't understand...I mean, the experts are saying there was never anything in the certification rule that you could really download anything although you might be able to download like a PDF document. So, if I'm wrong...

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

So, I disagree with...yeah, I disagree with that, every EHR that I'm aware of does allow the patient to download the common dataset in a C-CDA format and so that's pretty ubiquitous now and I thought even required under Stage 2, I could be wrong, but you are absolutely correct about the T part of it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

I'll tell you the API is what makes the T. The API is the T. So, they're just basically making up for some lost time in my opinion.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, so today...that makes sense, so today it's really view and you can download a C-CDA but it's not a transmit necessarily to a third-party App that's what the API would do and, you know, again, I think conceptually the Workgroup...we've all said this, you know, technically this solution has a really good purpose, gives a lot of choice and control to the patient on where they put their data but that there is a real problem with the legal framework and the Policy Committee...part of the reason I asked that ONC staff send out the letter, the transmittal letter from the Privacy and Security Workgroup, is that the Policy Committee is very, very clearly on record saying patients should not be surprised about uses of their data and they reference a lot of the Markel Foundation work. So, I think that work has yet to really be completed. So, folks want to take a look at that and send in comments as we refine the letter, you know, we'd obviously welcome that.

So, what I'm hearing in our discussion is to essentially say, yes we think this is a great solution technically we continue to have privacy and security concerns, generally, you know, sort of briefly describe them maybe give an example, as Clarke mentioned, and then ask the Privacy and Security Workgroup to weigh in so that...I mean, I think the trick is going to be if they weigh in on May 12th and they say, yes, there's no legal framework it's the wild-wild-west, you know, I think our support would probably get a little bit weaker for APIs and what we would want to do is immediately push for the policy gap to be filled so that we can get APIs done in a way that is not just secure but also protect patient privacy in a way that they expect it would. Are folks comfortable with that?

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

This is Nick, yes, Christine I think that's a very well stated objective for us. I guess I, as a privacy advocate, as well as being a technology advocate for patients, what I'm concerned about is actually an end game that threatens HIPAA.

As a patient downloads their data or gets their data through an API onto an App they may then share that with non-covered entities so they may well share it back to the same covered entities or to other covered entities and what you end up with are essentially multiple copies of data which are roughly the same that have completely different legal protections including almost zero and that, as you've pointed out, and I'm putting words into your mouth, are protected more by the whims of what developers put into their privacy policies than by regulation.

I think that if you...we had fairly strong comments from the FTC in their data broker's report in 2014 that immediate legislation was required to stop health information from being sucked up by data brokers and nothing has happened about that.

We have the recent draft Consumer Bill of Rights from the administration which takes, while flawed in some ways, takes a stronger pro-privacy position than anything we've seen in this country since HIPAA. These are really strong valid questions and I really don't want to see APIs bringing down HIPAA.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That's an interesting way to look at it I hadn't thought of that. What is the draft bill of rights that you're talking about? Who put that out?

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

The administration it came out in, about a month ago, six weeks ago now. I did a piece on the Health Affairs Blog on it for the...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Was it put out by OCR?

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

No it's put out by the White House, by the administration.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Oh, okay, we'll take a look at it and it's a consumer bill of rights?

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

That is correct; it's a consumer privacy bill of rights.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, got you.

Nicolas P. Terry, LLM – Co-Director, Hall Center for Law and Health – Indiana University Robert H. McKinney School of Law

I'll send you a link to my Blog post on it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great. Okay, great, okay, any other comments on this before we keep moving? Okay, all right so let's turn to the exclusion criteria which was a little bit down the page from, yeah, there we go, okay, so there are two issues here that we talked about on the last call one is about broadband. The language here stops short of saying you should or should not have an exclusion but simply states what the exclusion currently is, because I thought that would be helpful for everybody, and then just notes that CMS should really think about the fact that the number of mobile users is increasing and so that might be used in place of broadband and so I'm not sure, you know, basically what we're saying here is we are not completely sure that this exclusion should still apply.

The new piece that we did not completely discuss is an alternative that occurred to me that I think is consistent with the discussion which is what if you allowed providers in low broadband counties to offer access to patients and promote it so they would still have to offer 80% of their patients access within 24 hours but they would be excluded from the requirement if their patients actually 5% or 25%, or whatever the threshold is actually log on and view, download or transmit their health information in the reporting period. What do you guys think of that?

So, it would still get patients in those low broadband areas access but it would not require them to use that access. I think they would though if they...obviously, you know, they will when they need it. Thoughts? Any objections?

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Christine, this is MaryAnne and I think that's fair, you know, I frequently run into people who to this day get their Internet access from libraries, churches and the like so I think that...I saw that piece in there and it really made me think about how important that particular area of this work is.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great. Any other thoughts or comments on that? All right, so let's turn to the EP with no office visit. So, this is kind of interesting given our last discussion. I'm not sure if we would also support this in the same way, but basically the comment that we talked about last time is that there may be providers that have no office visits but who hold important data and how do we make that data available to them.

So, I wonder if there is a way...so the proposal here is basically if you only have a very limited dataset then maybe you don't have to implement a full portal but maybe you can do API only.

Now given the concerns that we kind of just talked about I wonder if what we should do is the same exclusion that I just outlined for broadband, which is there are kind of two options here, one is you keep the requirement exactly as they are, which they would have been in Stage 2 and they've proposed for Stage 3 and you keep it simple or do you try to complicate matters a little bit and say that, look if you have only one piece of the data that you can see in the bullet, so guys if you can scroll down a little, thanks.

So, if you only have...if you look at that list below care team member, we drew a line between care team member and medication allergies and said everything that medication allergies and below if you only have one piece of that data then you need to make that data available for patients to go on line, but you don't necessarily have to make them go on line and meet the second requirement of the threshold for a patient's actions. Does that make sense guys? Did I explain that sort of correctly? Any comments on this? Hello?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Christine, can you say it one more time?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, so, what I'm...so the idea here is if you divide this list between care team...everything below care team member, that if you, as a provider only have one of these data points that you don't...that you need to implement the view, download but you don't need to make your patients go on line and download, right?

So, this was like when I was saying, I think we talked about it last call, you have, you know, an optometrist who only has basically your prescription that's pretty much the data that the...my optometrist is going to have and so they need to implement a portal. They need to give or whatever, right, they need to do the view, download component but they don't need...they could be excluded from the 5% of patients go on line piece or what we know in Stage 2 is 5% what's been proposed as 22%. They might also be excluded from, you know, any patient-driven secure messaging requirement.

What do you guys think about that concept that if you only have one of these...if you've got a very limited dataset, which is all you have is a lab test or all you have is whatever then you need to make the data available but you don't have to force your patients on line if they don't need to?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

That's an interesting solution, this is Erin, and, you know, I think the office visit denominator, I mean, if I'm understanding it correctly that would also sort of exclude telemedicine visits, right? And I would imagine there are instances in which there is a virtual visit but patients still want access to that information and so this is a separate issue Christine, but just sort of tackling your proposal to change the denominator being an office visit.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No, I'm actually not...okay so that's a good clarification, I'm actually not...I think what we talked about before, and I may need to clarify this, was the fact that the office visit, Chitra did clarify to us, the office visit does include telemedicine, it does not have to be face-to-face.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Okay, sorry.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, sorry and I should have said that. So, it might be that...what I'm saying here is regardless of whether you have office visits there are definitely providers who have a very extremely limited dataset.

So, if you only have my prescription, my eye glasses prescription or you only have, you know, two laboratory tests that you had to do because you're a specialist, but you're still eligible for Meaningful Use, so you don't have any of this other data but that one piece, then you need to make the data available to me but you do not need...but you could be excluded from the requirement to have "x" percent of your patients actually go in and view, download or transmit that data.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

So, this is Erin, I wonder then if the Workgroup is comfortable with that recommendation if we need to make a parallel suggestion about what counts as a limited dataset, because I think there's like 16 items or something, I don't...it can't be if you only have 15 of those items don't worry the...you know, the actual usage metric won't count, you know, you won't have to worry about that. Does that make sense?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, so and on the screen I've put the dataset is listed there so what I'm...I think what I'm suggesting, well that is what I'm suggesting, is basically anything below...if you only have one thing...so the problem is this, right, you've got to draw a line between care team members and the data below it because everybody is going to have name, sex, date of birth, race, ethnicity and probably preferred language and care team member everybody in the world has to have most of that stuff if not all of it, but not everybody would have medication allergies all the way down.

So, maybe you do medication allergies through smoking status and you say, look if you only have one of these, and you don't have anything else on this list, then you can be excluded from the "x" percent of patients view, download, but you still have to make the data available to your patients.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

Christine, this is Clarke Ross, I'm uncomfortable with opening the door and then I'm more uncomfortable with only one of these, whatever "these" are and I'll give you my context.

I serve on three committees of the National Quality Forum and a couple of months ago CMS proposed that all dialysis providers maintain an up-to-date list of all medications that their patients are on and the dialysis people screamed and yelled and said "that's burdensome, we only do one thing, we only do dialysis, people are in an out with dialysis. We don't want to know about all this other stuff it's burdensome." And that's what I'm afraid of.

If we as a Workgroup say, yeah, you're excused for one thing and we aren't really precise on what the boundaries of the one thing are we're back into the dialysis people saying they shouldn't care or know all the medications a person's on and how dialysis might or might not impact that. So, that's my discomfort.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, yeah, that makes sense Clarke. So, I think what you're saying is, would this result in gaming the system so maybe providers start, you know, recording less data or somehow limiting their data so that they could qualify for this exclusion is that what you're saying?

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

Yeah, I am, because, you know, you used eye glasses and I don't have a problem with that, but I have a problem with dialysis and so how do we define the boundary around this so people can know.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, yeah, I mean, I totally take your point and I'm worried about it too. So, that's why I wanted to really talk about it today. I'll try to answer your question but I'm going to answer it as I think more of a matter of fact because I am worried about the gaming thing, but wanted to sort of flesh this out with you guys.

The boundary is that this only applies to Meaningful Use eligible providers number one and this would only apply to a Meaningful Use eligible provider who let's say only has one, you know, they have one, you know, kind of dataset around like...I got sent to a subspecialist by my primary care or my cardiologist, they sent me to a subspecialist and I went there for one purpose they have very little data on me, they sent the test back to my primary care practice so, you know, but they still have to pay to implement a portal, they still have to get 5% of their patients to go on line and view or download their health information even though I really, as a patient, really don't want to, because it's a very limited dataset. I would rather have you just make it available so I can maybe get it over to my primary care practice than making me go on line because you need to qualify for Meaningful Use, so make it available but don't make me go get it, but you're right it becomes complicated to try to identify potential gaming and things like that.

Any other comments on this, I think at this point folks are a little bit confused and concerned so we'll probably remove it unless anybody wants to argue with it or argue for it rather?

Okay, so I'll go ahead and remove this, so I'm going to take out the whole...I don't think we really have a comment on the exclusion here so I'll just go ahead and remove that and we'll get over to question six or objective six.

Okay, so, this is where we need to spend the rest of our time focused and that is...what I did was per the last call I've written out several options for the Workgroup to consider. So, the concern we had last time was that by conflating the concept of care coordination and patient engagement and then allowing the flexibility to do two out of three of these measures it would actually make it so that providers could end up doing only care coordination that has nothing to do with the patient in this objective and so while that's really important and care coordination totally matters, it's completely important, we need to be able to do both and not set up a construct that allows doctors to just do like one, right?

So, that was the concern we discussed last time and I forget if it was MaryAnne or Erin, or someone who had the idea of trying to separate out the concept and so I've done that here and proposed three options and what I'd like to do is we can leave the options in as long as you guys agree with them and, you know, we make whatever changes to them we need to, but say that our preferred option is option whatever and that's what we need to find...that's what we need to figure out today. So is that clear, any questions on that before I kind of dive in? Okay, so folks can...

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum
Well, this is Clarke, that's clear.

Christine Bechtel, MA – President – Bechtel Health Advisory Group
Okay.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum
And so I'm an advocate that all three measures should be separately defined and required and sort of rely on those on the Workgroup who know more about it on what the threshold should be. I really am beyond my depth when we get into the threshold but the principle, all three are important, all three should be separate and all three should be required is something...

Christine Bechtel, MA – President – Bechtel Health Advisory Group
Okay.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum
...

Christine Bechtel, MA – President – Bechtel Health Advisory Group
Great, so Clarke you just described Option A so if the computer webinar folks could scroll down for me, okay, keep going, all right so here's Option A which is exactly what Clarke just described, all three measures are required instead of two out of three, okay, that's Option A. That one I probably would leave in there just in case CMS keeps the measures as they are.

So, Option B is a little bit different, all three measures are required but one of them is modified, okay, so the first is 25% of patients do the view, download or transmit. The second is secure messaging and again this is secure messaging that's changed from Stage 2, it's not patients sending necessarily, it's the provider has sent a message to more than 35% of their patients or they've responded to a message that was sent by a patient, okay, so that's...so those two are exactly the same as proposed in the rules.

Then the modification that is suggested under Option B has to do with a patient generated health data measure, which is removing the option for data from a non-clinical setting and taking that and putting it in the health information exchange objective, objective eight. Is everybody tracking so far? Anybody not tracking?

Okay, so and the rationale was preserve patient generated health data as actually patient generated not just going out and getting data from another provider, okay, so that was that. So, that's Option B.

And then Option C is really the big separation of everything, okay, so the first measure would stay the same and that's the patients who view, download and transmit.

The second measure would remove provider generate secure messaging to the health information exchange objective and re-institute the Stage 2 secure messaging requirement where 5% of your patients send one secure message during the 12 month reporting period and that this would apply to EPs only because hospitals did not, I clarified this, they did not do...were not required to do secure messaging in Stage 2 so it wouldn't be fair to them to just spring it on them. I'm also not sure it makes any sense, but we're going to move...but they would still have to have the capacity for secure messaging because there is a provider send requirement that we've suggested goes under objective eight.

Okay, the third measure is just kind of what I just talked about with the PGHD piece where you're moving the non-clinical setting objective to HIE but maintaining the provider requested PGHD measure here in objective six. Okay, so that's the true separation of everything.

And what that means is that the HIE objective would be revised, if you guys could scroll down to...keep going, right there, perfect, thank you. So, you can see that the HIE objective would be revised and basically to say you are...there is only one measure instead of two that's in...this is the way I constructed it anyway, which is that we're not requiring you to like create the document...actually, hold on a minute...I don't know why there is a strike through that's not showing up in the PDF but it in the Word document.

So, what we're doing is saying make this objective be one measure not two, don't worry about creating the document that's the process worry about sending it, so focus on electronically exchanging either the summary of care record or the clinical information from a non-eligible Meaningful Use provider and you can use secure messaging to fulfill this requirement if you want.

And then the second measure in this objective is about receiving the summary of care and so that's again just adding the clinical information from a non-MU eligible provider option into that measure.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Christine, this is Erin, is the reference to common clinical dataset under measure one, should that read instead summary of care document or am I confused?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

The way I read the rule is that the common clinical dataset is what comprises the summary of care document.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Okay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That is the summary of care record so we can double check and Chitra maybe you can help me double check on that but I believe...Chitra are you on?

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

I'm here.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Yes, I think you're right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great, so we'll double check that but I believe the summary of care document is the common clinical dataset.

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So what we're doing is saying either you're sending the dataset as the summary of care or you're getting information from another non-eligible Meaningful Use provider. Other questions or responses?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Christine, back up on the suggested change to proposed measure three, first of all yeah, absolutely agree in breaking out the PGHD and making sure that the other is in the HIE requirement, so fully support that.

Between options, I would say, in my opinion Option B and C are good options and I think that when it comes to PGHD having it be 15% of all patients makes a lot of sense and of course the provider request or physician requested part for the reasons that you stated I think is an essential addition as well. So, that's where I'd throw my support. So, glad to see that separation.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

The separation of patient generated from the non-clinical you mean Phil?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah, the separation of the PGHD from the non-clinical, yeah, absolutely.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And I want to...I do want to call your attention to one thing that, and I struggled with this, so, you know, feel free to provide an alternative. The modification, so guys I'm looking under Option B here, bullet three, the modification that we discussed was about having patient generated health data but the threshold in the proposal was 15% of all unique patients and I suggested that I think it should be 15% of all appropriate patients and the reason is if you say 15% of all unique patients it means that you've got to get 15% of your entire patient population to fill out your survey or do your patient reported outcome measure, or whatever the case may be when your PGHD might apply to a smaller subset of your population, right?

So let's say you are an orthopedic practice and you want to work on a functional status assessment for patients who have had some very specific surgery and it would block you from selecting that option, even though it might be a really meaningful one to you, because that patient population would need to basically be probably 50% of your entire patient population in order for you to get surveys back from 15%. Does that make sense? So, what I've done here is just say this is appropriate not unique or you could go with...

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Well, you know, Christine...yeah, but Christine the downside of that is that if I'm a physician and I say, well, you know what I think these 10 patients are appropriate out of my panel of 2500 and so I'm going to go ahead and send an e-mail to them and ask them to let me know how their blood pressure is doing, right? Well, I've deemed that appropriate but its two patients out of 2500 at that point. And so, you know, I mean, that's really, really easy to game, right, I think?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, yeah, yes, no question about it and that's always going to be the challenge here. What I'm worried about is this Phil, if you...if they allow for two out of three, selection of two out of three measures people are going to pick the easiest ones and if this one is harder and it's not, you know, oh, God, you know, 15%...people were complaining with getting 5% of patients to view or download their health information, so getting 15% of your whole patient population to do anything I think people are going to be very worried about it and therefore they might be less likely to select this option which would totally defeat the purpose in the first place.

So, I was trying to find a way to balance those and I may not have found the right way, maybe it is to make it all unique patients but drop the percentage down to 5% or 100 people, I mean, right, you could put a number in there.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yes, I could put a number in there because, you know, if you're a surgeon who does very specialized surgery and you only have a small number of those then, you know, it's kind of...a number.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

I think a percentage is better than a number but I see your point and so I...but here's...let's kind of play this out. So, how do Meaningful Use requirements generally play out unless your VDT requirements unless...and then CMS just abruptly drops the percentage volume, so other than that scenario.

So generally, you know, you start with something, right, that you know is small and it sort of opens the door and then subsequent, you know, requirements expand on that, expand on the learning. So, I totally agree with you.

I think maybe a smaller percentage but I actually would keep it to unique patients and I think that really does open the door on PGHD. Even if we kept it at two out of three, you know, of the requirements...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Enough providers would choose it that it does open the door. Sorry, go ahead.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No that makes sense. What would you drop the threshold to 5...you want to do 5% which is what VDT started at?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

This is Erin, I'll just throw out that when the Policy Committee originally recommended the patient generated health data criterion back in, God, I don't know 2012, when they released their Request for Comment they suggested 10%, although it was a menu measure.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, okay that...and we were part of that so I think we did 10% and thank you Erin I couldn't remember that so that's helpful. I think we were saying 10% because it's a menu option. So, people are going to pick it who have that sort of...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Who can do it well.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Valid reason.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Yeah.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well and who thinks that they have a patient generated health data dataset, if you will, that applies to that percent of the population. So, I think 5 or 10% is I think more appropriate here and then it would go back to unique patients. So, anybody...I mean, want to...throw out 5 or 10%, you know, anybody want to talk about a preference there?

Normally, I will say, by the way that this small of an increment makes no difference in the threshold or in the performance, however, I think in this one case because it's a subset of the patient population it could make a difference in terms of making it more or less appealing because it will drive what type of patient generated health data you focus on because they're going to have to constitute a sufficient number of your population in order to get surveys back from 5% or something.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

I also wonder, this is Erin, if a specific percentage hinges upon whether we go with Option B or C because it's either, you know, Option B is three out of three and Option C is two out of three.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Right?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, although I think we should just be consistent that would be my recommendation.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Okay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

All right...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

I wonder if 5% will, you know, generate less ire and consternation, and hand wringing.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I have to say I'm leaning that way also.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah I would think so too. Christine how does this usually play out, is this a negotiation like we say 10 we know it's going to end at 5, you know, it's like being at the car dealer, right, you know if you come in at this amount their going to come back with this or will they say, okay, we'll consumer says 5% it's lower let's go with it?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

It's a good question and it totally depends on the threshold. So, the original threshold proposed for VDT was 10% by the Policy Committee and CMS did select 5%. There is a lot of pushback even to that today although providers are performing above, the median provider is performing at 30%. So, there is...there is definitely always pushback here, but, you know, then again they've taken lots of Policy Committee recommendations on measure thresholds exactly as they are.

The last set of recommendations we got on Meaningful Use, the Policy Committee got so hung up on threshold debate that we actually took it off the table and didn't suggest any threshold. So, it was, you know, it was a little bit of a mess. So...

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Well, I'll tell you what, if we end up at 5% PGHD and being required of the three different, you know, requirements, they're all required, that is huge for how patients become involved in their own care. So, I'd say that would be a big win if we can get that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Christine, this is Erin, I have another question, I just want to confirm that in both Option B and C you're proposing that the non-clinical data and that's not the best term for that kind of information...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

But what CMS outlines as non-clinical data wouldn't be lost in either option because in both B and C that non-clinical data would become a part of objective seven, am I reading this right?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes you are.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Okay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I think I was calling it objective eight, its objective seven, right, yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Oh, well whatever. So, whatever it's worth, I'm... and I don't know I keep going back and forth, I'm sort of leaning in the direction of Option B right now the reason because it seems maybe logistically less complicated or because it's closest to what CMS has proposed but is more meaningful in terms of patient and family engagement.

The other thing that intrigues me is keeping the secure messaging a requirement for both hospitals and eligible professionals but, you know, allowing those messages to be initiated by their provider on the hospital side, you know, could make it easier for them to achieve that measure and as I think Leslie was talking, mentioned last time, you know, I do think there's information hospitals have to share whether it's pre-surgery reminders or discharge instructions or whatever. So, that's what's making me sort of think Option B is a little more attractive but who knows I could change my mind in like 15 minutes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, sure. Any other thoughts?

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Christine, this is MaryAnne and I'm also waffling on my choice of A, B or C here, but just to point out that C as far as family caregivers goes seems quite attractive from the stand-point that when you're talking about exchanging information the non-clinical side or maybe that means exchanging information with long-term care down the road, that starts...for us that starts to move in the right direction as we talk about incorporating...I know long pole here, but as we start to think about incorporating social services, long-term care all those things that we know have to work together for families, so just a thought on that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That's...yeah, that's helpful MaryAnne, that's part of both Option B and C. We would still get the, you know...it would still be...in both options it would move that component...it would just move into the HIE objective but it would still be part of Meaningful Use for exactly the reason you outlined.

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Okay, fair enough, thanks.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And we...so I want to keep hearing people's thoughts and we don't have to select one if there is not a clear winner, if you guys are comfortable with proposing all three then, you know, you can let the policy makers or the Policy Committee, or whatever select and it's just great to lay out options. So, I don't want to force people into a selection but just want to get sort of a sense of where folks are at. So, other thoughts on this?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Christine, just for what it's worth, it's Phil, I would just say if we can represent a good solid point-of-view and a strong recommendation would seem more likely that one of them would be adopted and so, you know, it seems like we're thinking B or C and I'd love to see us hone in and make a strong recommendation, you know, I think again some of these things are essential, the physician requested, the separation out of the non-clinical, the requirement of all three. So, that's all good.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Do we have the time Christine to think about it some more and then since we have that other...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

I mean, I don't want to draw this out but I sense folks might need some more time to weigh the options.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

I don't know we might be not any more informed on Monday but it's just an idea.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, I agree. So, why don't we do this I'll open it up for one last time for comments on this and then there is one other issue that I definitely want to discuss before we end the call today, but in terms of next steps, I will revise the letter based on the conversation today and recirculate that if I can crank it out today we'll get it right back out to you guys later this afternoon, if not first thing in the morning and then you'll have two days to think about it and weigh in. We'll ask you to kind of...we'll see if there is any consensus in the group about the options that you're leaning towards and then if there is consensus it may...and everybody is comfortable with the letter than we can cancel the call on Monday.

If there is not consensus or somebody comes up with a new and brilliant idea or there...whatever then we'll still have the call on Monday. Does that sound like a good approach to folks?

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Kim J. Schofield – Advocacy Chair – Lupus Foundation of America

Yes, this is Kim, it does.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great and I'll...you know I do need to present to the Advanced Health Models Group tomorrow so they may have opinions but I'll present all three and say that we're kind of still pondering which one. Okay.

All right so the last issue that I'd like to talk about, it threads through all three options and it is a question about thresholds and the issue that I want to raise for this group is the 25% of patients view, download or transmit their health information through a portal or API, you know, pending input.

So, the 25% is I think...I'm concerned it's a big and scary number for people even though the performance right now the median performance for the Stage 2 attesting providers, who are definitely the leading edge providers by the way, is 31% I think and so it's coming close to that and I am worried because I'm worried that it's going to lead to a lot of gaming of the system out of concern that this will be the one measure that they can't meet.

So, we heard a lot this year from providers who were very, very worried about even the 5% and I'm just worried that going from 5 to 25% is going to cause people to game the crap out of the system. So, I want to see what you guys think and hear what your thoughts are.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

This is Erin, I mean, while I am...it's difficult for me to support, you know, reducing the threshold, I see what you're saying, I see where you're coming from as somebody who has basically been locked in a doctor's office until I signed up for their portal, until I was allowed to leave, I understand what you're talking about with the gaming and particularly with CMS's recent proposal to modify, you know, to totally undercut that 5% and reduce it to one patient. I worry that it might...I worry about setting such a high threshold at 25%.

I'll also note to your point about, you know, the median provider albeit those who are ahead of the curve performing at 30% we heard yesterday that at least among eligible professionals only 8% of doctors have successfully attested to Stage 2.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

And if you think about the doctors who should be in Stage 2 based on their trajectory and the program as a whole apparently that percentage increases to 16%, but if only 16% of people who should be in Stage 2 are doing VDT, I don't know it's a lot of numbers, but my point is I think you raise an interesting...it's something we should seriously consider.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah and you make a good point which is, you know, as I said these are the leading edge providers but it's a small number that are attesting and their attesting early and, you know, I think they're not the small practices of the world and I, you know, Erin I've heard your story before I don't want patients to get locked in the exam room and told not to come out until they sign onto the portal and send a test message, you know, so...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Oh, no the test message was fake the doctor sent that to themselves but that's another story.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Oh, yeah, even better, good God. Other folks?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Christine, remind us what is the Stage 2 requirement again? Is it 5% or is it one patient, what did it come to?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

It's 5%. CMS proposed in a new an unrelated twist or new and directly related twist a couple of weeks ago a series of potential changes to Stage 2 one of which was to change both the secure messaging requirement and the VDT requirement to be one patient, which, you know, you talk about gaming, I mean, oh, my goodness, you know, the doctor's spouse could be the one patient, right, so there is a huge backlash against that from the consumer community and even some technology folks and providers and so, you know, that's what that was a reference to.

So, it is a little odd that in one rule they make this drastic reduction and then in the other rule they make this huge jump up and so trying to find a middle ground...I really do think that finding a middle ground is going to a better approach here than saying 25% even though, you know, there...for a lot of folks that's a hard pill to swallow because you kind of don't want to be, you know "oh, yeah, we just need fewer patients to do that" but on the other hand I think...I don't want patients to get gamed in that process and having to, you know, being forced into action so that's my first concern.

My second concern is that if they do leave the measures as they are and they only require two out of three to be done no one will do this, no one will hang their Meaningful Use money on their ability to get a quarter of their entire patient population to view, download and transmit. Now they have a 12 month period to do it but CMS has been reducing over and over again the reporting period to 90 days. If they were to do that to try to get 25% of your patients in 90 days is like ridiculous. So, I really lean to reducing that number...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

I also...this is...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...thrust for...

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Sorry. I was just going to say, this is Erin, I wonder if that will also make it more likely for us to successfully advance the proposal that it's three out of three.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

It definitely would, absolutely. In my opinion and based on past experience that's, you know, my opinion, but yes it would make it more likely I believe.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

So, we're likely working from a Stage 2 requirement change to one patient is that right so if that's...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No, no.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

You think it's the 5% is where we end up?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Yeah, so changing it to 10 would be a full doubling that's even aggressive, but I think that's probably what we should represent, you know, as being somewhat aggressive on.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah. Other folks have thoughts? So Phil is throwing out 10% which is a doubling of Stage 2.

MaryAnne Sterling, CEA – Co-Founder – Connected Health Resources; Principal – Sterling Health IT Consulting, LLC

Christine, this is MaryAnne, I could definitely support 10% and I think it's defensible too.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Clarke Ross, DPA – Consortium for Citizens with Disabilities Workgroup – The National Quality Forum

This is Clarke I'm good.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. Anybody else? Okay, all right, thanks you guys these are the questions that have been keeping me up at night so this is great. I think we had a really, really good discussion. I will go through and make changes to this letter and then send it back out to you guys for further comments. So, we have to go...so let's start with open the lines for public comment first then we'll come back and see if anybody has anything closing and I'll give some next steps and then we'll go back to public comment.

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Caitlin, can you please open the lines?

Caitlin Chastain – Junior Project Manager – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press *1 at this time.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so any last comments from the Workgroup on any aspects of our discussion today?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Hey, Christine, it's Phil, I do have one additional thing that I'd like to either have the Workgroup maybe investigate a little bit more or maybe you have some answers if we do a Monday call, certainly don't need to take more time here on it, but in some of your comments you made reference to the APIs as potentially adding complexity and I think your statement was a good one and that is, if they were different and proprietary APIs from the EHR companies, those were the words that you used, and from Dan what he actually seemed to represent was that the APIs would be published in public so that they wouldn't be "proprietary" and all different but rather standardized. That's a really big deal when it comes to consumers being able to access it using the applications of their choice and so I think that's worthy of some clarification.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so, yeah, I agree and I was trying to describe that earlier so I'll repeat the suggestion that I made, no one objected to it at the time, but I'll do a quick repeat in case there are any, which is that I think the letter of the comments need to clarify the fact and so I would add on to that section that talks about, you know, potentially adding complexity, I would add on to that a statement that says, however, CMS should...CMS and ONC should ensure that they are open...they are published and public, I'm getting my p's mixed up, published and public APIs that would avoid the complexity issue, but we do need to make sure that's very clear in the rule.

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Thank you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, I'm suggesting that I add that clarification if nobody objects. So, does anybody object first of all? And would that answer the concern Phil?

Philip Marshall, MD, MPH – Founder & Chief Product Officer – Conversa Health

Oh, it absolutely would. I'm sorry if I misread it earlier, it absolutely would, thank you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That's okay, I might have been talking too fast. All right, any objections to that? Okay. Any other comments? Okay, so public comments?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

We have written comments that were submitted by Sherry Reynolds for the Alliance for Health. So, the first comment is, rather than developing different metrics for patients wouldn't it be more powerful to say that everyone on the care team including patients and their family care team needs the same real-time access to health information versus separate rules for patients.

The second comment was for the summary of care measures I would recommend that you include patients as a possible recipient since many people are sent home for follow-up care. This will also support the role of patients as members of their own care team.

Sherry also submitted the link to the White House Privacy Bill of Rights so we'll share that as well.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great, thanks Sherry and Michelle will you send me the written stuff so I can take a closer look?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Sure.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great, okay, terrific, any other comments, public comments?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

That's it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great, thank you. So, guys what I'll do is, again, clean this up, get you a new draft. I will present it based on the most recent discussion tomorrow to the Advanced Health Models Workgroup and then we will decide whether or not we need a call on Monday. So, by Friday I really do need to hear from everybody with a kind of yay or nay on the comments and if there is anything you can't live with, you know, or whatever let me know and then we'll definitely need to have a call.

Alternatively, if the Advanced Health Models folks come back and they want us to consider some, you know, radically new ideas or whatever then we'll have that call on Monday. So, please hold that calendar invite for Monday, hold that time and we will let you know as soon as we do, which is probably Friday about whether or not we'll need that. So, apologies to Phil because it's a 9:30 a.m. Eastern Time call but that was the only thing we could do that day, so sorry Phil...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Christine, I'm sorry...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

We had a public comment that just came in if we want to take it?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, sure go ahead.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

I know we're out of time, but, Susan I'll let you say your last name Susan, just a reminder public comment is limited to three minutes so please go ahead Susan.

Susan M. Mateja – Policy Administrator – Delaware Health & Social Services Division of Medicaid and Medical Assistance

Yes, hi, it's Susan Mateja from Delaware Health and Social Services Division of Medicaid and Medical Assistance, how are you? Can everyone hear me?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

We can hear you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, go ahead Susan.

Susan M. Mateja – Policy Administrator – Delaware Health & Social Services Division of Medicaid and Medical Assistance

Okay, great. I want to go back to where we were talking about the amount of time, I'm thinking that 25 days is a lot, okay, and, all right, so help me out here, all right, so 25 days is a lot and 3 days is a little. When we go actually into what we need to respond to for the audit I think that we need to actually go forth with a solid amount that we want to go with.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Susan, this is Christine from the Workgroup. I think I'm completely lost on your comment. So, I'm happy to keep listening, but I don't understand what timeline you're referring to.

Susan M. Mateja – Policy Administrator – Delaware Health & Social Services Division of Medicaid and Medical Assistance

Okay, my apologies on that, okay, we were talking about the actual audit strategy.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No we haven't talked about an audit strategy on this call unless I'm missing something.

Susan M. Mateja – Policy Administrator – Delaware Health & Social Services Division of Medicaid and Medical Assistance

Okay, we talked about Meaningful Use, Meaningful Use audit strategy, we have actually talked about that, right?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No, we'll go ahead and take your comment but we're not...this is the Consumer Workgroup and we're not making comments on the audit strategy but just go ahead and make your comment and I'm sure the folks at ONC will pick it up.

Susan M. Mateja – Policy Administrator – Delaware Health & Social Services Division of Medicaid and Medical Assistance

Well, that's fine I'll go ahead and make my comment, okay, so, we were actually talking about the difference between having 25 days, 10 days, 3 days, 5 days, okay, so now I'm saying that I think if we go forth with our actual comments that we need to make sure that we go streamlined with something that we can all deal with as far as states and...so I'm thinking that something more like a 5 day or 10 day would be better and that's my comment.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Okay, thank you Susan. If you have more written comment we're happy to accept it via e-mail as well. Christine we also just got another written comment from Mark Underwood, if it's okay with Mark I'll share that with the Workgroup as we are already over time, so my apologies.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

But we'll make sure we have more time in the future to walk through the public comment sorry about that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, okay, yeah, I always think we're leaving enough time for them to come in but they're coming in I guess kind of late, later than I thought. So, that's fine maybe we'll open for public comment 10 minutes early and then go from there. Okay.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you, Christine.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

All right, well, thanks everybody and we'll talk to you potentially Monday, we'll let you know for sure by Friday. Thanks.

Erin Mackay, MPH – Associate Director, Health Information Technology Programs – National Partnership for Women & Families

Thank you, Christine.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thanks everyone.

Public Comment Received During the Meeting

1. Alliance4Health - Rather than developing different metrics for patients wouldn't it be more powerful to say that everyone on the care team(including patients and their family care teams) needs the same real times access to health information vs separate rules for patients?
2. Here is the link to the White House Privacy Bill of Rights
<https://www.whitehouse.gov/sites/default/files/omb/legislative/letters/cpbr-act-of-2015-discussion-draft.pdf>
3. More people now use their cell phones to access the web so the low broadband exemption shouldn't play an impact

4. Alliance4Health - For the Summary of Care Measures I would recommend that you include Patients as a possible recipient since many people are sent home for follow-up care. This will also support the role of patients as members of their own care team
5. I apologize if this has been covered in previous meetings. Regarding incentives for providing patient rights to transmit: I worry that the MU3 objective doesn't specify that the EHR be transmitted directly to an external PHR under the control of patients. The portal and download alternatives are weak for several reasons. (1) These options rely on technology sponsored by the health system or insurer. If the consumer changes health plans, the consumer can lose access to all their EHR data. (2) Also, the allowance of "download" as an option is unrealistic for voluminous data. Do we expect that consumers will rekey all their data into a separate PHR? What about access to digital information for caregivers and family when vigorous treatment is in progress? Without a transmit requirement, the consumer would be deprived of timely, digital information that could be shared with family members or non-network providers, or pharmacists.
6. Great discussion, and great opportunity for patients!