

**HIT Standards Committee
Privacy and Security Workgroup
Transcript
March 21, 2014**

Presentation

Operator

Lines bridged with the public.

Michelle Consolazio – 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 Standards Committee's Privacy and Security 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 the meeting is being transcribed and recorded. I'll now take roll. Dixie Baker?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I'm here.

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

Hi Dixie. Lisa Gallagher?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Here.

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

Hi Lisa. Walter Suarez? Chad Hirsch? Dave McCallie?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Here.

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

Hi Dave. Ed Larsen? John Blair? John Moehrke?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I'm here.

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

Hi John. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi Leslie. Mike Davis? Peter Kaufman?

Peter N. Kaufman, MD – Chief Medical Officer & Vice President Physician IT Services – DrFirst

Here.

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

Hi Peter. Sharon Terry? Tonya Dorsey? And is Julie Chua on from ONC?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yes, I'm here.

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

Hi Julie. With that I'll turn it back to you Dixie.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, I want to begin by thanking you all for calling in. I know it's kind of hard to call in on these phone calls on a Friday so I appreciate you taking the time to do this. Hopefully, we will make it through the rest of the NPRM today that's the only thing we have on our agenda today. So, with that Lisa do you have anything you want to add?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

No Dixie, that's fine, thank you.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay. Julie Chua and her team have integrated our – oh, the network connectivity was lost, is that true with everybody or just me?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

I'm up.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Ah, there it is again. Oh, okay.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

It seems okay for me.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

It must be just me. At any rate, they have integrated our comments from the last time into the slides. I know it's sometimes hard to see the slides or it certainly is for me because I work from a laptop, so Julie has also distributed the slide deck file. So, hopefully, between the two you can see what's going on.

Okay, can we go to the next slide please? This is just the assigned topics Julie and her team have split these bullets into the topics that were specifically assigned for our Workgroup to address and those that her team thought that we might want to comment on.

Now of these requested topics my understanding is that we've made it through end-user device encryption. So, let's move ahead to the next slide which is the potential topics and we haven't started on those. Next slide, please. These are tertiary, keep going. Okay, keep going. Just keep going until you get to the first one with red on it. There.

The red indicates some slight rewording changes that were made since our last meeting and pursuant to our discussion at our last meeting. This one, oh, I keep losing connectivity here, I don't know, let me bring up the slides instead; maybe I should have double connectivity let me turn that on.

So, this one on access control, authentication access control and authorization we added specific references to 800-63 LoA 3 and we also, at the second bullet on the – at the bottom, we said, we're not aware of any Meaningful Use measures or other healthcare policy that would warrant a general requirement for two-factor authentication but if they do decide that on this requirement then we suggested they consider the DEA audit and we once again referred back to the fact that the only way they could really certify is through functional testing that we know of no standards to cite at this point. Any further discussion on that? Okay, let's go to the next one please.

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

Hi, Dixie, I just wanted to let you know I'm here, Walter, sorry.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Thank you, thank you Walter. The one on auditable events and tamper resistance, we had a considerable discussion about this and it was basically – I had to go back – I went back to actually what they, you know, what they really were proposing, which was a whole new requirement that you not be able to disable the audit.

So, the slide 10, let me see what we have here, slide 10, I'm looking at two things at once here, slide 10 shows the changes that we made and basically we didn't really change the basic content having seen the Office of Inspector General's, you know, the real motivation for this change to begin with, but we – bottom line we suggested no change from the 2014 final rule that the – we acknowledged that the existing criteria don't preclude the audit log from being disabled, but it does require access controls that restrict that capability to those authorized and presumably those who have audit log administrative duties.

And we pointed out that really adding this requirement could restrict, could, you know, impede the administrator's ability to do their job and that's kind of the bottom line there. If you'd like to read through that wording if you have any comments before we go forward. Okay, next slide please.

Okay, audit reports, oh, this is the 2147 one. Next slide. This is the one having to do with ASTM 2147 and these are the comments that we gave at our last meeting. We said it was updated a year ago and we don't know any reason why, you know, why they should need to add a definition of query.

They asked whether, it was an odd question actually, they asked whether they should add functional requirements so strictly for the purpose of auditing, being able to audit those requirements. So, we said that typically one audit security relevant actions associated with performing required functions; one doesn't require functions so that they can be audited. And so we're opposed to creating new functional requirements just so they can be audited. It seems like kind of a silly question, but I didn't put it's a silly question.

We also recommended that they cite all of Section 7 of ASTM 2147 rather than just those specific sections that are not marked optional. We had discussion at the last time about 2147 that it also has, I think sections – it has several sections that deal with audit, but so I wanted to make sure I understood that you guys want to just say, include all of Section 7, you don't want to say, we'll also consider Section 6 or something like that, right?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I thought we were going to open up because the ASTM specification does have a list of the kinds of events that are security relevant and I think if that was pointed to people wouldn't be confused by looking at Section 7 and thinking Section 7 was a description of the kinds of events. So, that was kind of the tradeoff that we were looking – at least I was trying to bring forth.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

That they – I'm sorry, I don't quite understand what you're saying? I know that it has one section in Section 7 that lists these 5, I think it's 5 events, types of – oh, the data, data elements that need to be collected is that what you're saying?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Well, yeah, Section 7 is the data elements that need to be collected.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

But since they don't point at Section 5 which says these are the kinds of events that –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

One should collect the data elements for people are misunderstanding Section 7, you know, that's where this query thing comes up right?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Because in Section 7 there is the type of event and people are looking at that going "oh, those are the only types of events I need to audit."

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I know exactly what your – yeah, yeah, I –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

So, that's all I really wanted to do was mention that.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So, you want to mention that whole thing? That Section 5 – what are you asking them – are you asking them to do anything about Section 5?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Well, I think that is the section that we – that would be appropriate, right? And I can bring it up and we can edit off line, but I think that was the crux.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, yeah, Section 7 is just nothing but the data elements.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

If you would like to provide us a sentence or two to clarify that, that would be really helpful. Can you do that?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Sure.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, thank you John, I appreciate it. Okay, okay.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Hi, Dixie, this is Julie, I just need to clarify when we speak of Section 7 and Section 5 we mean 7.5 and 7.7 is that correct?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

No.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

No.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Both Section 5 and Section 7 of –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Of the whole 2147?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Yes.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare
Yeah, the, yeah.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Okay, okay, thank you.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare
And that's exactly the reason why I want to bring forth Section 5 because people are not recognizing that there is a whole section that speaks to what are the auditable events.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Yeah and most of 2147 is about audit there is just one section about accounting for disclosures and one about sanctions but the majority is about healthcare auditing, it's, you know, ideally suited for this purpose. I don't know why they're questioning it.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare
Well, I think the reason and we talked about it last time is that it does also talk about disclosure login.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare
And they don't want to potentially step on, you know, cross those streams if you will, but whatever.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Yeah, that's what I said, it has disclosures and it has sanctions and I understand why they don't want to step on either of those actually. Okay, next slide please. See I lost this connection again, but, okay, here we go. Next slide, please.

This is about amendments and we said of amendments that we don't recommend changing the criterion. Okay, the next slide please, log off, auto log off emergency access, let me just move this – keep going please. And we didn't recommend changing either these criteria. Keep going. I want to get to the new ones if we can. Next slide, please.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare
We're up to accounting of disclosures.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Yeah and you aren't – you guys none of you are experiencing these lost connectivity right, just me?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare
Yeah, I'm not.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
I'm not.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Just making sure the group doesn't want to talk about integrity?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

We do.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

We do that's the next one.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, that's the slide prior, yeah, thank you.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes that's our next one as I remember. Let me see, let me make sure, yeah, end-user device, yeah, integrity that's the next one we need to address. Okay, Julie you want to take over here?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, so for the last two topics we have integrity and accounting of disclosures and for integrity the background for that is the Privacy and Security Workgroup comments on the 2014 NPRM were integrated into the testing procedures based on the 2014 final rule.

So, our ask is just trying to get the Workgroup to see if there are any standards related concerns that ONC should be made aware of, because there are no proposed changes from the 2014 final rule.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I think that's appropriate.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

What was being, this is David, what was the – what is the testing for integrity? It's a – I don't remember what –

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Yeah that would be helpful for me too.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yeah, let me look that up real quick.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I think it may just be that you demonstrate that you're using the right protocol that validate data integrity of the messages that move on them but I honestly don't remember.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Right, okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I don't know.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I seem to recall it was primarily attestation.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I don't – I've never even looked at it so I have no idea. But what do we – I don't think we have much – are you asking about the criteria?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I don't have any recommendations for improvement to –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer

– Office of the National Coordinator for Health Information Technology

Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I don't think there have been any recent advances in integrity.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah, the only thing, you know, that we could do is as we bring on new transports make sure that we, you know, address in that transport how integrity is handled.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yes.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

So, it's more of a philosophy than necessarily a line item.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, next slide. Julie are you the one that's typing too?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer

– Office of the National Coordinator for Health Information Technology

Me and MITRE is on the call too.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Somebody is typing; it's coming across the line.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer

– Office of the National Coordinator for Health Information Technology

Oh, I'm on mute though when I type.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Oh, okay. Accounting of disclosures?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer

– Office of the National Coordinator for Health Information Technology

Yes, okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay this should be a good one.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

All right. So, for accounting of disclosures –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

It's not –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

There are proposed changes from the 2014 rule and ONC is proposing that this criterion no longer be optional as such a designation would no longer be necessary because of the discontinuation of the complete EHR concept.

And some background information is ONC's decision making on this criterion revolves around the fact that HHS/OCR has not issued a formal rule on the HITECH Act's impact on accounting of disclosures and this lack of formal guidance is underlying ONC's plans to continue to exclude this criterion from the base EHR definition.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So –

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

I'm sorry, are you saying that they want to put the criteria in because we don't have a final rule?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

No, I think what they're saying is since we're – since editing is going to modular or whatever the word is –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

This should just be listed as any other module that a vendor could claim that way, you know, the optionality is more named. Other than that I don't think there is any other change proposed right?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

That's correct.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

I'm still – I'm sorry but I'm still not understanding. So, it would be a requirement for each module?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

No.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Or it would not be?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Well, the main question is does the Workgroup have any concerns related to ONC's decision to make this a mandatory certification criteria, criterion, sorry.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Well, but they just mention the fact that –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

For each or for one?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

We don't have a final rule, so I don't understand why we would change it until we have a final rule.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I agree, why would they change it?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, what would be –

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

What is the question?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Meaning the final rule from OCR?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

I mean, that was the reason it was optional in the first place and that hasn't changed.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

So, they're saying there is something to do with eliminating the complete EHR concept but I'm not making the connection.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Is this back, Dixie this is Leslie, do you remember we had the discussion way back when that said that the complete EHR had to demonstrate all of the accounting of disclosures and all the security and that a subordinate module could use that or could also be independently certified but there was nothing that reflected a swath across all modules and that this then would address the fact that a module could simply be for accounting of disclosures and sort of a layer across all modules. That's what I'm reading. Am I reading this all wrong?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

I'm confused.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I don't think it has –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

And I think you are one of the factors that come up here is that accounting of disclosures is at the organizational level.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

And the reality is most disclosures are not even known to have happened by the EHR because they happen as part of workflow procedures or external, or you know ancillary applications. So that was why it was not –

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

But don't forget –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Not pulled in.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Don't forget that the draft accounting of disclosures rule had a requirement for an access report which was very controversial.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Right.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

And so it has been on hold or we don't have a final rule.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Right.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

And so it was optional because we didn't have a final rule.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Right, but that would have been the access report; the access report was distinct from accounting of disclosures.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

No it's still there until we get a final rule.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

It's still there. I totally agree with Lisa. I don't see what compelling reasons – I know that for example the Tiger Team has made very explicit recommendations on both the access report and the accounting of disclosures and I would – I don't see any reason why change it before the ruling itself, the final rule itself is out. I think that – I think Lisa hit it on the head. I think that's what we should say.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay. Does the Workgroup want me to get clarification on what the connection is with the discontinuation of the complete EHR?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

No.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

No, okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

No, I don't think that has anything to do with it. The fact is the ruling hasn't changed so why should they change the criterion.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

And really we have no idea what the final rule is going to look like. I mean, they're talking about doing pilots and other things.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

So, it could change in another direction we don't know.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, yeah it could totally, yeah, I totally agree. So, next slide, please.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

We're ready –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Go ahead, Dixie, sorry?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

No, no we're ready to start our secondary topics, yay!

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, so, yay, we've gone through the assigned topics for the Workgroup and so this slide shows some secondary topics that the team has taken out and basically what we want to do is we have some slides for the EHR certification module, the Blue Button and disaster preparedness, and we wanted the Workgroup to discuss as a group to see if they want to weigh in on all of these or there are only certain topics that you really want to have a discussion on.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So, let's see what you have.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So, for, let's start with the EHR certification module which is on the next slide, please.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So Blue Button Plus is in – well, this one too is in 2017. Go back to that previous slide. Maybe – so I can see it. There are two of them view, download, transmit that has an "x" and transitions of care has a question mark. Oh, that just asks is there – maybe, oh, I see those are 2015, but it's all in the NPRM, okay, let's just keep going straight.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Okay, next slide.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
Okay, so for the next slide it talks about the certification policy for EHR modules.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Okay.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
And what we are asking is, there are four potential approaches for certification for the 2017 NPRM including the Privacy and Security Workgroup's minimal set criteria. So, there are four options here that they are asking opinions on. So, I'm going to go through all four.

The first one is should we re-adopt the 2011 edition which required EHR modules meet all P&S certification criteria unless it is demonstrated that the privacy and security capabilities are either technically infeasible or inapplicable. So, let's do that first option, first.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Well, let's read through all the options so we know.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
Okay, the second option is to maintain the 2014 edition which made the privacy and security certification criteria part of the base EHR definition that all EPs, EHs and CAHs must have EHR technology certified to meet in order to ultimately have EHR technology satisfied through the cert definition.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
In other words, option 2; I know that's a little confusing.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
That's a convoluted way of saying the 2014 edition – because all of that, the base EHR has nothing to do with certification it has to do with Meaningful Use, how you qualify for Meaningful Use.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
That's right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Option 2, I mean, the 2014 approach is the one that this group really opposed adamantly because it made – it did not require any EHR module to be certified against the privacy and security criteria or to demonstrate how they would, you know, how they would get their security capability. Three is our recommendation.

**Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer
– Office of the National Coordinator for Health Information Technology**
Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Which was to – which was to require them to either – require a module either to be certified against all the privacy and security criteria or they would describe how they are going to integrate with an external, with other modules or with an external security capability.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Number four, I lost my connectivity once again, that's fun, okay and then number four is what, adopt a limited approach.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yes, so a limited set of your – of the privacy and security functionality that every EHR module would be required to address to be certified.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, I don't know why we wouldn't want to recommend what we recommended before I thought it was right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

How is three different from four besides the word "minimal set" versus "limited set?"

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Remember our discussion about the, maybe you don't, because that discussion happened in the full Standards Committee meeting not in this – this Workgroup decided that this minimal set, we decided that the minimal set was a minimal set, we decided just a couple of things in security and then the Standards Committee decided, in the final transmittal letter, that this minimal set was really most of the capabilities, I think all of them actually, I think it was all of them.

So, it sounds like option four is going back to what this Workgroup recommended.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

So, the difference between three and four is there is a different list of what's mandatory?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, yeah, I could actually tell you what those were. The, yeah –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Doesn't three allow them on an individual basis to get around the limited functionality rules if they can prove that they shouldn't need to do it for their uses?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

No option three and four –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Option three –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Are identical except four is this Workgroup's recommendation and the set was limited and I could tell you, I'll look –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Up what they were if you like.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst
Yeah, it's great to have that history.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Yeah, yeah, let's see it was, when did we do that?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
I have it right here Dixie.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Okay, oh, good.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
So, the minimal set from the Workgroup was authentication, access control and authorization, auditable events and tamper resistance, audit reports, amendments, automatic log off, emergency access, encryption of data at REST and integrity. That was the minimal set from the March 26th recommendations.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Transmittal?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Is that from the transmittal or from this Workgroup? Because, I thought this Workgroup had a much more minimal, minimal.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
From the Workgroup this is the one where the group had recommendations on the privacy and security criteria for EHR modules.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
I know but what are you reading from the transmittal?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Well, that is the full Workgroup. This Workgroup – no that's the full committee. This Workgroup never sends a transmittal. Transmittals are always from the full Workgroup. What's the date? Maybe I'll look it up.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
What I have here is the March 26, 2013.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Okay.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
And that's what we referenced I think.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie; I do have a question though. When it isn't applicable, when something is an EHR module or a system connecting that doesn't require security, is that also part of our original suggestion?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

What?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The words up above that say, where technically infeasible or incapable in option number one.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

That was part of our recommendation. If it didn't make sense for a module –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, I just wanted –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

That, yeah –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, I wanted to make sure that was still there, thank you.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, yeah, now what's the date of the transmittal Julie?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

March 26, 2013.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, so that would have been probably our February presentation here. Let me see. I don't know I'll have to – it seems that would be the February meeting.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

It was presented; I'm just looking through, presented on December 19, 2012 to the committee.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay then I'll look then, okay. Here it is Privacy and Security Workgroup, here we go I found it. Okay, the minimal set has this new, let me see, this has 8 different things, but I know that in the discussion, maybe they – yeah the minimal set that we presented does include 8 different things, authentication, access control and authorization which is one, auditable events, tamper resistance, audit report, amendments, automatic log off, emergency access, encryption of data at REST and integrity. So, those were the same things that went forward in the transmittal?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

So, of those the things that I'm kind of thinking might not apply to all possible cases are things around emergency access, because many clinics don't have emergency access.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, we said they could – if any of them that didn't apply they could justify why not.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

But these are the – that's what I have here, yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Okay. I mean if you have that escape clause it really doesn't matter than does it?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, well that's what –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Is there anything –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

That's what the full committee said, yeah, that's what they said.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah as soon as you throw in the escape clause then, you know, then people will argue for what their own minimal set is versus saying we accept and modify your minimal set.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Let me tell you exactly what – here, I have the presentation.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah, okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Here's exactly what we said, for 2016 edition EHR certification each module presented for certification should be required to meet each privacy and security criterion using one of the following three paths.

The first path is demonstrate through security documentation and certification testing that the EHR module includes functionality that fully conforms to the privacy and security certification criterion.

Option two, or path two, demonstrate through system documentation sufficiently detailed to enable integration that the EHR module has implemented service interfaces that enable it to access external services necessary to conform to the privacy and security certification criterion.

Option three, path three, demonstrate through documentation that the privacy and security certification criterion is inappropriate or is inapplicable or would be technically infeasible for the EHR module to meet. That's what we said.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

That I remember.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

And that is, that is beautifully written.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I think it's still what we would say.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah, but that's not any of these options.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, that's number three, that's option –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Is it?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Okay, I would – if you think it's three say three and then, you know, for emphasis include a copy of the things –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

We wrote before.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

I agree.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Because forcing the EHR vendor to be transparent I think is the most critical piece here.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah. Yeah, I think we already had – you know, option four has ONC establishing this limited set and we've got the out there. So, okay, we're going to just stick with our – and I'll send that, what I just read to you Julie to just include it in our response.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, sounds good.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay. Next. Blue Button Plus. David are you on here this is your favorite topic?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, what are the questions they're asking us?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So, what are they asking us?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Let's see –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So, there are three questions that the 2015 NPRM is asking comments on, one is, if there is a market need for Blue Button Plus certification that would developers find value if they could say they're Blue Button Plus compliant or Blue Button Plus ready.

The next two questions are which elements of the Blue Button Plus Direct would be most appropriate to reference in a certification criterion and how would they be tested.

And number three is for Blue Button Plus REST specs.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

What are they talking about what elements of them? You know, don't you either say, you know, the Direct is the push and REST is the pull.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Right, because the REST they don't change the content specifications but it does include like authentication and authorization using OAuth and OpenID and transport using FHIR instead of the Direct protocol.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right, but what are they talking about, I know that –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

What do they mean by what elements? Are they asking us to pick those specs apart or something?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I think so.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, I –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

So, I think –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

And how would they be tested.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I mean, I think that the market is likely to go beyond what Blue Button Plus defined although I think it will be an extension of what they've defined, in other words, it will use the OAuth 2 model, albeit maybe with some further vetting, because it hasn't been very thoroughly vetted and it will use FHIR for access but it won't limit it to CDAs it will probably expand it to include, you know, Direct, FHIR query of resources so that you don't have to go through the intermediary of the CDA which is really quite a cumbersome way to just pull down your current medication profile if that's what you need.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Now remember Blue Button Plus uses FHIR only for the query part of it.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I know that's what I'm saying is that I think what the market is going to do, regardless of what we do in this, you know, back water of certification, the market is going to explore the use of the combination of FHIR more generically with OAuth 2 for authorization, you know, call it the smart platform as applied to mobile.

So, in other words I think it's an extension of the work that was started, good work, excellent work, started by the Blue Button Plus, so I'm a little bit at loss – I don't want us to set a standard for three years out that is way behind where the market has gotten to.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree with David, this is Leslie, I think we have to – whatever this answer has to demonstrate is or reflect is the evolution that's coming out of Blue Button and moving to FHIR.

What we don't want to do is constrain or stop momentum that's already started because we see in the future that the current standard will evolve.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And then –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, that's why they're asking – I mean, I see a huge market need for Blue Button Plus, but are they asking a different question, is there a market need for Blue Button Plus certification.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Well, and so my question is why would we be certifying something if it's not part of Meaningful Use? I mean –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well it is.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I think they're point is to put – if they put this into Meaningful Use then the vendors get an added marketability to say not only am I Meaningful Use certified but I'm Blue Button Plus certified all in one pass.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

And it is part of Meaningful Use David because it's used for view, download and transmit.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

No not the query capability.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Transmit to a third-party.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, that's what it's for.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

That's push, this is pull. The current VDT is push only.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Oh, that's right, that's right, yeah push would be the – yeah the push would be transmit to third-party.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Well, I'm saying –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

No, but pull is too, because that gives you the implementation where the user is wanting, has an App on their mobile phone and they want to use that App to transmit their EHR to a third-party, to that App.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But that's not –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

But today in Meaningful Use it's not as rich as what Blue Button Plus defines.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

The view, download, transfer is a high-level concept of view, download and transfer and it doesn't specifically bind together a viewable version of the document along with the CDA encoded version of the document.

Blue Button Plus puts those things together and says, let's create an enhanced content, which is, you know, this combination of these things and that then becomes the minimal, let's create a mechanism by which those are sent with Direct, so number two isn't far off from what's in the specification today, but it really speaks more to making that functionality available to patients versus it's not really obvious that today's Meaningful Use criteria allow patients to use Direct to send their content.

And then the third one, you know, there really isn't anything that specifies that you have to have that capability, although, as David, you know, and others have pointed out, many EHRs are at least providing the functionality if not specifically using these technologies.

I will immediately then say, I totally agree with David for us to point at Blue Button Plus today would potentially stop people from looking at the more mature and maturing technology in the NIST, OAuth profiling and the FHIR and IGMHD profiling with, you know, even beyond that. So, I would be worried that it starts to hold back –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, it's premature, it's premature closure here. I mean, I think we can say we encourage further piloting and development of the capabilities that were started with Blue Button Plus but this is such a fast moving space with FHIR emerging rapidly, with OAuth maturing, OpenID maturing that we'd be really ill advised to suggest they certify around the current Blue Button Plus specification. That would be –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, I think also it would be – if we look at the NwHIN Power Team's criteria I think it wouldn't pass, because it certainly isn't in broad use at this point.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, it's ready for pilot. I mean, I think this is –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah it's ready to be piloted, yeah, that's exactly right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

More piloting needed and I think we'll see a lot of activity in this space over the next two years.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I think so too, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

You know, John had come up with words, this is Leslie, about suitable for purpose and directional or directionally appropriate as a way to address that same sort of emerging but not solid areas that we talked about in standards for patient generated health data and perhaps this is an area where we can say directionally appropriate that kind of language.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I think we should stick with the words that the readiness criteria say, you know, those readiness criteria that they're encouraging us to use for this NPRM review in fact are either ready to become, you know, the national standard or ready for piloting, or emerging. So, what David is saying is we put them in that bucket, you know, under those criteria it would go in that ready for piloting bucket, which means ONC –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Invest in some piloting.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah and I think, you know, ONC and/or the market, I mean, the market is going to be doing aggressive mHealth stuff once FHIR gets supported by vendors. OAuth 2 is the obvious right way to manage the authentication but the details, the profiling is probably still work to be done.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I think we should encourage the direction –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But it's premature to certify.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yes, yeah, indeed the standards in both OAuth and FHIR they've already changed and improved from the version that Blue Button snapped.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right, right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So, what we want to say, Julie and team, is that the market certainly is ready for these kinds of technologies and so we want to encourage the direction that Blue Button Plus takes and the use of the standards that Blue Button Plus uses and we also want to support further piloting of Blue Button Plus, but we don't want to explicitly say, make Blue Button Plus a certifiable capability.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

In its current state.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

In its current state, yes, until further piloting is done.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And development. I think it's going to need, you know, it's an iterative – you don't want to just pilot the current state and say it works and then consider that certification worthy I think it's an evolving set of capabilities.

So, you know, the current Blue Button Plus only lets you download a CCD, I mean, that's clearly – if you can do FHIR for a CCD why wouldn't you support FHIR for the medications.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I mean, no one is going to handicap their Apps to just download a CCD if all of FHIR is available. So, my point is that it's not just piloting it's really further development and piloting.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, further, yeah, yeah. And cite the NwHIN Power Team's criteria for readiness, readiness criteria; we would consider this ready for piloting and in need of further development before it's ready to become a national standard. Yeah, that's good, that's real good, yeah. Okay.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, good.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Do you have all three there Julie?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yes I do.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Good, all right.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, so next slide, is disaster preparedness. The background for this is one of the key issues encountered during disasters and emergency care is how to bypass the naming of patients who are temporarily unidentified. This is a rare issue in other case settings but disasters and emergencies create situations in which care must begin before the identity of the patient can be verified.

So, for the 2015 NPRM we are asking whether there could be standardized naming conventions for EHR technology to use for temporarily naming unidentified patients during disaster and emergency events, that's the first ask.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yikes. Why would you, out of curiosity, need a standard naming convention is the assumption that this standard would be somehow so standard it could propagate to other EHRs magically?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

I'm not sure what they're naming.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Their naming patients.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

If they use them to – why, I don't understand that either. I mean, each hospital would have its own –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Well, this is –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

They have their own numbering system anyway.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

This is Peter, I'm not –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Is that Joe Doe 1, Joe Doe 2?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Sorry, I'm also a first responder so I've been involved in situations like this where there is, you know, something that happens, there are 12 patients, you don't know the names of 4 of them who are unconscious, there is no family member immediately available, you don't want to take more than a second to put anything in and if you're putting data in you want to just assign them something.

Now then if they get transferred from you to an ambulance, from the ambulance to the hospital and you still don't have a name for them it would be great if the different systems could not have to create a name also or change the name but you could still identify them and tie them in with the tablets the first responders were using, the ambulance computers the ambulance was using, which they don't actually have computers for either of those yet, but they hopefully will by 2017, and then the computers in the hospital.

So, I understand what they're asking for and you could always use just patient 1, patient 2, patient 3, but then what if three different ambulances come in that have, you know, from different parts of the disaster and they each have a patient 1, patient 2, patient 3, I think you would need something that identifies the source as well.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah we can generate 64 character oids and stamp it on them or something.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Well, I was hoping for something simpler.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I mean, Peter that's a great explanation of the use case, my concern is to do that in a coordinated fashion is not an EHR issue that's a, you know, whoever is managing –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Disaster preparedness issue.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah, it's part of a regional disaster preparedness planning, right?

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

And the chance of the EHRs that we're talking about needing to accept those names, you know, for the vast majority of EHRs their office EHRs, they're not going to deal with it all.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

It's only the hospital ER systems that are going to need that.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

What I don't understand is that – and I know others have said this already today, but what is this have to do with Meaningful Use?

And, you know, Meaningful Use criteria I think or objectives generally come from CMS and they have to do with standard delivery of care and even like the first line in this slide says ONC is interested in creating a new – has CMS come up with Meaningful Use, a measure in this area?

What's the connection in Meaningful Use I don't get it?

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Well, with questions like that we could all go home.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, this is Leslie, it's making sure that when you come back up that you have the ability to now cross pollinate patients within your systems from you particular downtime procedure and so that there is a convention that the EHR would accept as a standard.

So, I can understand the use case, especially thinking back to Katrina or areas where there are multiple systems and multiple areas going down, how do you reconcile patients after the fact. If there is a standard at least data gathering opportunity you have the chance of being able to reconcile patients.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But to make this work and I think it's very feasible to build something like this it's just hard to see how it fits into what we've been asked here, but to make it work you'd have to have some kind of a tagging system that, you know, put an armband or a wrist band with a machine generated number, unique number and then the EHRs would scan that number and say, you know, this is John Doe number 27, because that's what, you know, that's what number it was up to when somebody tagged him with the band, but that requires that somebody develop all the tagging and the banding stuff which is not an EHR problem.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

I think there are two reasons we should ignore question one, one is as Dixie said, there is no Meaningful Use request for anything like this and the second one is that ONC should not be generating this, this should come from disaster preparedness people, you know, to come up with a way to tag them in the first place.

And the most we should do is to say, you know, if there is a standard for uniquely identifying unidentified patients in a disaster that hospital information systems that, you know, deal with emergency care would be able to accept that standard, something of that nature, because I don't think we're going to write the standard and I think it's really a policy issue more than a standards issues at this point because there is no policy around it.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, that's a really good point. Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

–

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

I learned that for you Dixie, you taught me about that policy thing.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I do think we could make a comment along the lines that is there were a standard for, you know, bar coding of unidentified patients EHRs could read those bar codes but such a standard doesn't exist at this point.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Well –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

I don't think I would say bar code because we're talking about 2017 they may give them an RFID or something, you know, who knows what they'll be doing four years from now, probably bar coding, but I would just say a standard way of identifying unidentified patients that the system would –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, well it would have to –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Have to read and accept it.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It's a standard way of marking them.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, it could be as simple as a cell phone number.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It's a standard way of marking it.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

But everything we're talking about is policy and procedure and, you know, we need to come up with what's the technology impact and –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

You know, whether you're reading a bar code or, you know, text from a keyboard it's just, you know, an identifier.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

So, but –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

So, I'm not sure what is our role here without the policies to guide us.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I mean, I think that – and I'm agreeing I don't think that they need a lot of input from us on this, but it's pretty clear that you'd need something that could read a tag on a patient for this approach to make any sense and when I say tag I mean whatever is the appropriate magic technology of 2017 albeit RFID or near-field or good old fashioned bar code, but we don't have such a technology and –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

What are you, you know, David you and John, and, you know, a little less so probably for Peter, but for the EHR vendors when you read this what do you think you need to do? Your products need to do?

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Nothing.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Well, if somebody is –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Because that's what we're talking about, EHR products, what do they need to do?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Well, if the disaster preparedness community says we're going to standardize on this particular approach to tagging victims then the EHR vendors would just put a reader for whatever that tagging mechanism is so that you could bar code in the patient or wand in the patient and know who you were dealing with –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

With respect to a tag that had been applied by the disaster triagers.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So, it's –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It's just a reader.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Certification requirement the ability to integrate a tag reader?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I mean, what is the certification requirement trying to get to here? I don't get it.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah, I don't see anything new here, whether it is the daily workflow or it is identified from a disaster, the need is still already there. So, I don't see a technology path here.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It seems like they're asking us if there is a right answer to the question of how would we tag victims of a disaster and I think the answer is "no there isn't a right answer to that question" you've got to settle that through some other process.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes, I agree, I agree.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It's not going to come from certification.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

And as far as the ONC is interested in creating – as far as asking us whether there are – whether we have any specific certification criteria to recommend I think our answer is no.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right, it would depend on the mechanism chosen to tag the patients.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, hi, this is Julie, I just wanted to remind the group that these are, what do you call this, secondary topics and there is actually the Implementation Taskforce who is also tackling this as an assigned topic.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Good.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I just wanted to let you guys know that.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Good.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yeah, okay.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, let's go onto the next one.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So, as I said earlier, we came up with a list for the Workgroup to discuss if they wanted to weigh in on certain things, so for the VDT, the transmit criteria, ToC and secure messaging, we didn't put slides together yet until we knew if you guys really wanted to weigh in on those or not, just from historical knowledge of what these are and if there are certain topics that you really want to make sure we discuss.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

VDT, oh, I see VDT at the bottom, okay. So, you're asking us whether we want you to create slides on implantable device list?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

No, actually, Michelle can you go to slide three please? Okay, so slide three this is where we restarted with the secondary topics, so we've already discussed EHR module certification, Blue Button Plus and disaster preparedness. For the last four topics we wanted to get the Workgroup's opinion if you want us to go into these at all?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Have they changed any of those?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Hold on, let me look at one slide – topics, secondary topics, okay so for VDT there are 2015 edition issues and comments requested for transmit criteria –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Somebody is crinkling something I can't hear you.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, somebody is eating their food or something.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yeah, for ToC there is comment requested for secure messaging no requested changes. So, in essence VDT and ToC are the ones that have some changes proposed.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Do you know the nature of changes to VDT?

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

For VDT and ToC it's kind of connected and high level knowledge that I know of is they are trying to decouple the transport and content specifications for those.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I was – I sat in on the Implementation Workgroup call this morning.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And we discussed some of that. The one issue that came up that just sort of stunned me that does have security implication is a very vaguely worded requirement being proposed that in the view, download and transmit that if a patient puts in any Direct address that the EHR would be required to send to it no matter what and that generated a lot of pushback from the Implementation folks to say you can't send, you know, Direct will not allow you to send to a non-trusted receiver.

So, if you don't have a trust relationship with the receiver's address you can't send to it and I think the Implementation Group all agreed that this was an unrealistic request. But if we want to weigh in on that one more from the security point-of-view that would certainly be a candidate if we wanted to buttress that opinion.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Well, what's interesting is we've heard from previous HHS leadership that the patient can request that their data be sent to any location regardless of whether it's encrypted or not.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That's true.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And I think that that's a reasonable capability, but you can't saddle Direct with that capability.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Ah, true, yes, you know, if the point is that it will be sent using Direct then absolutely there is a mismatch there.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah and that's all – we were just saying you can't call that Direct you could just say general e-mail or something but you can't call it Direct without re-defining Direct.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Correct.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think why that gets very confusing, this is Leslie, is because the intent originally was that at the patient's direction information can be sent to – a provider to another provider and that is transmit but also in the idea that the patient can present to a provider and say “hey, send my record download it or send it to this address in the clear” and those are two different use cases, because VDT is all about a provider to provider at the patient’s request –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

In a secure transmission and so I think that’s where if it is using Direct that is secure. If it’s a request for “send it to this e-mail address” that’s in a clear and not part of VDT that’s what I understand.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right and the way it was written is it requires that send to any address but it couples it to Direct which is –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Got you.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

That’s where there is a mismatch.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

But are we – so, David do you want us to say, to, you know, weigh in on that as well or –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

There was a unanimous agreement in the Implementation Workgroup that it made no sense to say that you could send to any Direct address even if you didn’t trust it. So, I don’t think there’s going to be a lot of pushback on that from ONC because it would break Direct, it would require, you know, throwing it out –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And starting over. So, I do think that there was quite a bit of discussion about, you know, these, the state of affairs that since not all Direct HISPs have figured out how to trust each other we’ve created some artificial barriers, I’ll say artificial, but some barriers that what I’ve been calling islands of trust that have made, you know, Direct not as ubiquitous as we had hoped, but that’s not a technology issue it’s a governance issue and I don’t think we need to weigh in on it. I mean, we know it’s a problem but it’s not going to be solved by changing the technology.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Correct.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right, it might be something that this Workgroup may want to weigh in on but not in the context of the NPRM though.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Well, that’s possible, I mean, I think it’s a good subject for the Standards Committee to –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

You know clarify that there are policy issues out there that need resolution.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, it might be – yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But, yeah, I don't think it's –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Maybe the Consumer Group Leslie that might be even better to highlight it.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

No but it's a problem even from provider to provider and I think if we can't solve it in the provider/provider space –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

That's true, yeah, yeah, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think it has to be a professional title agnostic and it is a good opportunity for both the Consumer Group and Provider Group discussing this together.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But it's real clear when you talk to the parties that are having a hard time getting agreement that it's not technology issues it's definitions of things like "what does it mean to trust you" and one group has set one criteria, the VA has set another criteria and the states have set yet another criteria and they are all unwilling, at the moment to budge and to allow the other guys criteria to count.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And the market –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

And that's without, that's without the complexity of patients.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, exactly, exactly John.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

It's too expensive for patients that's the problem.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

We need – you know we might as a committee want to say, Direct is great and it's a good way to start but it shouldn't be the only one that's required if there are other standards, you know, there's got to be a way to open this up especially for patients.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, you know what maybe, you know, she has on this slide we're looking at secure messaging, maybe that's an opportunity for us to bring this up, maybe we just put that as a comment, because right now Direct is the main secure messaging standard in the certification criteria.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But my point is this problem will exist irrespective of the standard, it has nothing to do with Direct.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I know but the standards create it, make it a bigger problem for healthcare because they lock into Direct.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

No.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

No not always, go pick an alternate secure messaging standard and you're going to have the exact same problem. The only way to make the problem go away is to drop the need for secure standard and just say use e-mail but we know that's not acceptable either.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Well, you said it was discussed this morning that patients could ask for sending of their data unsecure, which is potentially the way that they get out of that, but it's not Direct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's not Direct but it's not VDT, right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Then –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

So they might come up with another name for it, whatever, but, I mean really –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

It's a governance –

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

If it's not a standard.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

It goes back to –

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Well, again it's policy but if we had a portal standard patients don't mind using portals they mind using 6 portals, every doctor has a different portal.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, well that's – talk about a real policy issue.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah that's not going to get any better.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree with – I agree with David though this is a continued swirl around the trusted agreements across these entities that will actually, this lack of trust, create a downfall for every one of these in some way shape or form.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Now having been, you know, having, you know, painted the bad picture I think there is in fact a ton of momentum around DirectTrust as lots of HISPs, many, I don't know more than 40 or 50, many major IDNs that have joined it, I think DirectTrust has tremendous momentum but it's not a finished process, it's not settled yet, but it's policy.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It's not technology.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree and it's still in work and I think a couple of states signed on this week, so I think we're getting momentum, everyone wants to get there it's just work.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

It really, to quote David from Wednesday, you know, we really need to have done what we recommended when we reviewed the governance NPRM, you know, they came out after that and decided that they didn't need any governance and that's really where it fell apart.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, although the battles over who runs the governance would have been just as messy, so I'm not sure, you know –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes, okay, I think we're running out of steam.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So, I think –

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

Dixie and Julie, maybe I can suggest that you guys touch base off line about some of these topics and just see –

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yes.

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

If it's necessary for the next meeting to walk through some of these things.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Exactly.

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

And we can give people back a few minutes of their Friday afternoon which I'm sure they want back.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

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

With that do you want to open to public comment Dixie?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

Public Comment

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

Okay, operator can you please open the lines?

Caitlin Collins – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. 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. We do not have any comment at this time.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, thanks again to everybody for dialing in and John I see I got the e-mail from you so thank you and have a good weekend everybody.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Thanks.

Julie Chua, PMP, CAP, CISSP – Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Thank you very much everyone.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Bye-bye.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Bye-bye.

Peter N. Kaufman, MD – Chief Medical Officer & Vice President, Physician IT Services – DrFirst

Bye.

John Moehrke – Principal Engineer, Interoperability & Security – GE Healthcare

Bye.