

**HIT Policy Committee
Privacy & Security Tiger Team
Transcript
January 7, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you, good afternoon everyone. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Privacy and Security Tiger Team. This is a public call and there is time for public comment built into the agenda and the call is also being recorded so please make sure you identify yourself when speaking. I'll now go through the roll call. Deven McGraw?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Deven. Paul Egerman? Dixie Baker?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Dixie. Neil Calman? Judy Faulkner?

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Judy. Leslie Francis? Gayle Harrell? John Houston?

John Houston – University of Pittsburgh Medical Center

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, John. David McCallie?

David McCallie, Jr., MD – Cerner Corporation – Vice President

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Wes Rishel?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Wes. Latanya Sweeney? Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Micky. And Kitt Winter?

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kitt and are there any ONC staff members on the line?

Kathryn Marchesini – Office of the National Coordinator

Kathryn Marchesini.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kathryn.

Scott Weinstein, J.D. – Office of the National Coordinator

Scott Weinstein.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Scott.

Joy Pritts – Office of the National Coordinator

Joy Pritts.

MacKenzie Robertson – Office of the National Coordinator

Hey, Joy. Okay, with that I'll turn it back to you, Deven.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Thanks, MacKenzie, I know I heard we also have David Holtzman from the Office for Civil Rights on the line too, right?

MacKenzie Robertson – Office of the National Coordinator

Yes. David are you there?

David Holtzman, JD, CIPP/G – Office for Civil Rights

I'm here, I'm here.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

All right, great, thanks, David. It's always good to have your input; it's very helpful. So, today we intend to focus on a discussion of policy implications of query and response models for health information exchange, health information exchange as a noun not the verb, not limited to the verb health information exchange otherwise also called an HIO we're really focusing on the noun here and just to sort of close the loop on our recommendations on patient ID-proofing and authentication which are going to be presented to the Policy Committee tomorrow we incorporated everyone's suggestions who put them in by e-mail, Judy, including the one that you sent out this morning.

So, I want to thank folks for taking a look at those and responding if they saw concerns or wanted to make sure that this was articulated appropriately and so we'll be, Paul and I will be presenting those to the Policy Committee tomorrow thanks to everyone for your hard work on those. Thanks also to all the folks who testified at the hearing we had on it and people who sent us information who were not invited to testify including those who posted on the blog, all really helpful information. I think we've got some good recommendations to put before the committee and I am hopeful that we'll get a good result there tomorrow.

So, with that I want to turn to what we're going to try to do today, which is to really, we're saying continue the discussion of query. We had a very brief discussion on this at our meeting, I believe it was in December, and we were not able to make significant progress. The most we were able to do was to tee up a number of sort of questions that we have tried to get some slides to try to help resolve if they come up again on things such as how does the Data Use and Reciprocal Support Agreement, otherwise known as the DURSA, handle policy around query and response, and then also there were some questions about the sort of technical confidentiality codes that are currently in the header for the C-CDA.

So, we do have some, at least preliminary information to address those questions if they come up again today, but I really want to focus this call on policy. What are the policy implications of the Information Exchange Workgroup's recommendation on EHR certification criteria for query that are included in the RFC? We're specifically going to take a look at what we have said about the issue of consent in previous recommendations and see if that particular model that's now out for comment in the RFC is consistent with those recommendations but I think we also want to explore other types of query models and think through how our previous recommendations would apply there or if we wanted to modify in some way what we said previously about consent.

This is an opportunity for us to really think about query models of health information exchange where a provider or an entity goes out and seeks information about a patient versus the situation where you have information about the patient that you then are seeking to share with someone else. And we ideally want to be positioned to respond to any comments that come in from the public on these particular issues as a result of the RFC, which for those of you haven't had your heads to ... nails to the grind ... I can't even think of the metaphor, if you haven't been working on your own set of comments to the RFC, if you have been you're well aware that this deadline is fast approaching if not we will as a Tiger Team be asked to help respond to some of the comments that come in on that and the deadline is January 14th.

So, with that we're going to look through what's actually in this Information Exchange Workgroup recommendation that did get included in the Request for Comment and the idea here is not to look at that recommendation to judge whether it is phrased appropriately, whether it is the right technical model for EHR certification, whether EHRs ought to be certified for query, for any particular query capability at all I think is really not what is on the table for us, that's kind of out of our purview.

Our job is to sort of use that model as a way to sort of think about whether, if in fact, that was a model that the Policy Committee would recommend pursuit of, how does that gel with our previous recommendations on consent. And then I think we also want to think through, well if not that technical model, but there are other query models out there, how would our recommendations apply in those context and we may need to do some thinking about what those other models, existing models look like.

Linda Koontz, who helps us out from MITRE has begun the process of researching what some of those other query models look like and I know folks on the call have experience with different query models and so I think we want to start sort of thinking through what some of those use cases look like so that in addition to the model that's currently on the table we can think about the policy implications of other existing query models and kind of pressure test what we've said before about consent against those query models.

And then of course, as I mentioned, we do have some slides that, they're not in the backup section, I don't intend to go through them per se, but we have them available should we need to get further information on the confidentiality codes that are part of the consolidated CDA as well as applicable provisions of again the DURSA, which is the data sharing agreement that entities that are part of what was once called NwHIN Exchange and is now called eHealth Exchange have to sign in order to be part of that particular network, it's not a universally applicable document, but the entities that are part of that particular network do sign it.

So, with that I just want to check and see if anybody else has joined onto the call since we started? Okay, so, we'll just move right into some slides about what in fact is in the Information Exchange recommendation on query technical capability, it's been proposed as a potential certification criteria for the next phase. I think a lot of people refer to it as Stage 3 of certification and it is part of the Request for Comment that's currently circulating for public comment.

So, essentially how this is set out is that the EHR has to be able to query another entity for outside records and to also be able to respond to those queries. The outside entity receiving the query could be another EHR system, it could be a Health Information Exchange “noun” HIE/HIO or it could be an entity that’s on the NwHIN Exchange, again now called eHealth Exchange just by way of example, but the idea is that there would be a query capability in the EHR that would enable query for any of these pathways and the query could consist of three transactions, a query for patient records based on demographics and other available identifiers as well as the requester and the purpose for the request, a query for a document list based on an identified patient, and then a request that’s actually for a specific set of documents that are on this list.

Again, I want to re-emphasize that this is a model for technical capability within an EHR. It in and of itself doesn’t attempt to change or re-order policy but create technical capability, but the policy implications of that technical capability are in fact what we want to talk about today.

So, then the other part of this is on the receiving end, when an EHR receives an inbound query they have to be able to technically be capable of telling the querying system whether the patient’s authorization is required to retrieve the records and where to get that language. Of course, if that authorization is already on file it may not be required. At the direction of the record-holding institution, and I underscored this on the slides for a reason, the EHR has to then be able to respond with a list of the patient’s releasable documents based on the patient’s authorization and at the direction of that record holding institution then the EHR has to be able to release the specific documents with the patient’s authorization.

And then the last part of this particular proposed technical capability is that the EHR that initiates the query must be able to query an outside entity for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient’s records and this is clearly in a circumstance where the record holding institution doesn’t have one on file or if in fact the querying institution actually has a legal obligation to get the consent of the patient before collecting the data. And then of course, once the patient has provided the authorization the EHR has to have the capability to send that form to the entities who requested it and then having ... or an electronic notification attesting to the collection of the patient’s signature.

So, that is in fact what’s in the RFC as a proposed sort of technical capability that should it actually be adopted for the next stage of certification would be part of sort of the capabilities that EHRs would have to demonstrate.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Question?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

This is Wes.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Can you go back about three slides?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

This one?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yes.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I want to make sure that I understand the first bullet here. The way I interpret it the response to that query is not health information ... patient, it's simply a list of, an answer of whether we know the identity of this patient or not, whether, based on the information you provide we can identify this patient or not.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, so, I actually think I may have gone back one slide too far, so this slide, and actually Micky, I'm really glad we have you since you are the Chair of the IE Workgroup, because I want to make sure I explain this right. This is about what the query ability has to be, so this is the "ask." The machine has to be able to do a patient query based on demographics as well as be able to identify who the requester is and the purpose of the request and they have to be able to query for a document list, and they have to be able to query a set of documents. So, this is all the technical capability around the "ask" and then this next slide, slide 5, is around the technical capability of the response.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, so if could go back to the previous slide.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Are you meaning to imply that these could all be done in one interaction or are you meaning to describe three separate interactions here? There's a policy issue around the first bullet, which is why I'm asking the question.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

So, I don't think it's clear from the way that it's described, but certainly what is clear to me, and based on the discussions of the IE Workgroup that I was able to participate in, I think at a minimum the system has to have the capability of doing each of these. What I don't think is well answered by the current language is whether that capability has to be all three at once or all three separately or both.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, I think that's right, Deven. This is Micky. And, you know, just to be fair, I mean, what we had laid out and this was a subgroup that was really headed and really driven by Larry Garber and Peter DeVault, so they spent a lot of time working on it, but then at one point what we did was we stepped back and recognizing that we we're going to have a Request for Comment, then, you know, there were some details that we just literally stopped and said, well if a lot of this is going to be in a Request for Comment why don't we put it out there for comment and see what we get back rather than trying to, you know, develop too fine point an answer that we're going to end up revisiting anyway.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

Micky Tripathi – Massachusetts eHealth Collaborative

But that said, I think, you know, Deven, that you stated it correctly, which was the idea was that there are certain sets of things that need to happen, now whether those are all sort of concatenated in one particular transaction or it's a series of back and forth, I mean those are things that really weren't specified. I recognize though that there are policy implications too, whether those are a part of the same thing or whether you would have to separate them for, you know, policy thresholds that you'd need to meet for ... in order to be able to conduct the next transaction if this was actually a series, I suspect that's what you're getting at.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

Deven, this Paul, I just wanted to let you know I'm on the call now.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Oh, great, thank you.

David McCallie, Jr., MD – Cerner Corporation – Vice President

This is David, I second the notion that the answer to some of these technical questions does have policy implications and there may be simpler ways to do this than the three steps listed here or better ways to do it I guess is a better way to say it.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, so I think we should, this is Deven, you know, acknowledge that this was put out for public comment and that it's not necessarily our job to try to improve upon it from a technical capability stand-point, but for purposes of our policy discussion I think we will need to sort of assume a range of possible interpretations. Does that make sense?

David McCallie, Jr., MD – Cerner Corporation – Vice President

So, yeah, this is David again, that makes sense. So, we should really focus on the question of the consent issue and how the consent works?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

I think, I mean, we have certainly structured these slides so that at least the initial phase of our discussion about policy issues that are implicated by query models such as this one would be around how our previous recommendations on consent would be applied, but it also has occurred to us, to Paul and to me, and to ONC staff as we have worked to prepare these slides for you today, that there may be some other issues that are privacy related that are not necessarily just about patient consent that we should surface and we're certainly open to hearing about what those are as we have these discussions. In fact, we want to hear what those are.

Paul Egerman – Businessman/Software Entrepreneur

So, why don't we go on through the slides?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay. So, now we're to the point where I want to remind folks about what we did say about the issue of consent or patient authorization in particular in our previous recommendations on this topic. First off, we were very careful in our recommendation letter to note that our recommendations apply to the exchange of identifiable health information to meet the Stage 1 requirements of meaningful use and specifically exchange of information for treatment and public health purposes and we noted at the time ... and these page references by the way are references to our recommendation letter, which is available on-line.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Which slide are we on, Deven?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

We are on slide 7.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Okay, I'm not seeing that yet.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Oh, okay, it's on my screen.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Sounds, good, maybe I'm just ...

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Am I the only one who has it? That would not be good; we need to be on slide 7.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Now I've got it, now I've got it.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, all right, we noted also at the time that we probably would need to do additional work to think about how our recommendations that apply to Stage 1 would apply in other exchange circumstances. We also said that the trust framework for exchange among providers for treatment requires some assurance that providers on both ends of the transaction have a treatment relationship with the subject of the information and that a provider who is requesting information should, at a minimum, provide attestation of his or her treatment relationship with the individual who is the subject of the information that is being sought.

We went on to say that what we called directed exchange among patient's treating providers the sending of identifiable health information from provider A to provider B is generally consistent with patient expectations and does not require patient consent beyond what is required in current law or what has been customary practice.

Paul Egerman – Businessman/Software Entrepreneur

Is that on slide 8?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes, sorry, thank you, Paul, we are on slide 8, second bullet on slide 8. When the decision to disclose or exchange the patient's identifiable health information from the provider's record is not in control of the provider or that provider's OHCA, Organized Health Care Arrangement, then patients should be able to exercise meaningful consent to their participation.

Moving to slide 9, we then provided a few examples of circumstances that would trigger our recommendation that the patients have what we went on to call meaningful choice about participating in an arrangement where the decision to disclose the information was not necessarily in the hands of the record holding provider or that provider's OHCA.

And examples would include a health information organization that operates as a centralized model which retains identifiable patient data and makes that information available to other parties. An HIO operates as a federated model but still exercises control over the ability to access individual patient data or the information is aggregated outside the auspices of the provider of OHCA and comingled with information about the patient from other sources. These were the examples that we came up with at the time.

And so, now I'm on slide 10, the recommendations that we made were based on these core values that are in fact part of our recommendation letter that was endorsed by the Policy Committee that the relationship between the patient and his or her health care provider is the foundation for trust in health information exchange and that we must consider patient needs and expectations. Patients should not be surprised about or harmed by collections, uses or disclosures of their information.

MacKenzie Robertson – Office of the National Coordinator

Sorry, this is MacKenzie; I'm just going to ask everyone who is not speaking to please mute your phone because we're getting some background noise, thanks.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Thank you, MacKenzie. Okay, so now I hit "next slide" and I have no slide, so can we have the next slide, please?

Caitlin Collins – Altarum Institute

Yeah, we're on slide 11 now and Deven it looks like you've actually been kicked off the webinar.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Ah, okay, well good thing I have the paper right in front of me, so I won't worry about that right now. But, I'll make sure to do ... I won't attempt to advance the slide by myself. Okay, so, you know, clearly our previous recommendations on consent assume that there's a decision maker at the receiving end of a query and that this decision maker has some discretion about whether or not to provide the requested records.

Again, recall going back to the slides on the particular model that's in the Request for Comment where it makes very clear that the EHR, the capabilities to query in the EHR system would be done at the direction of the record holding institution. So, on one level you could sort of look at that and say, well that assumes that there is this decision making capability on the part of the recording holding institution where they would make a decision about whether to release the records or not, or even a document list for that matter.

But, it's not entirely clear that all query models leave room for this discretion, you know, we certainly surmised in our own examples, in our original set of recommendations that there were exchange models where that, you know, decision-making capability was absent and that those types of models would trigger consent, but, you know, we did that a couple of years ago and there are, you know, other models out there that we may be familiar with that Linda Koontz from MITRE is asking us to surface that we should also probably consider with respect to policies around query.

The other thing that we wanted to note on this slide 11, and David Holtzman from the Office for Civil Rights can certainly chime in and correct us if we're not entirely accurate about this, but, you know, clearly a query model puts entities in a position of being able to go out and collect information about a patient, and HIPAA really focuses on what covered entities and business associates are permitted to do with information once they have it. It doesn't really sort of govern the circumstances under which you are permitted, you know, to reach out and get information from another source.

So, HIPAA doesn't provide the sort of backstop of rules for this particular type of arrangement although certainly there are some state laws that may in fact govern the capability of collecting information about a patient, but in terms of HIPAA it doesn't cover those issues.

John Houston – University of Pittsburgh Medical Center

So, hey, Deven, this is John Houston.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes?

John Houston – University of Pittsburgh Medical Center

Just, so I understand what you're saying, you're saying that what we're really trying to do is or maybe I'm telegraphing what you're asking is that what we're trying to do is understand how we could better support the notion that the requester has an appropriate reason to ask for the information not just that the sender has to be sure that any time they send information that it's based upon a consent. Does that make ...?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, no, I mean, I think we're trying to identify the circumstances where our previous recommendations on when a patient's meaningful choice should be acquired, you know, before a patient's information is made available through a certain exchange model, how does that apply when it's not a situation ... in a query type of model where you have a patient who is in your office or who was scheduled for an appointment with you and you want to, in advance, or onsite get information that might help you treat them, you know, just using a treatment context and what are the circumstances under which you can acquire it.

Again, our previous recommendations assumed in fact that people would ask for information when they needed it for treatment purposes because we were in Stage 1 of meaningful use and certainly Stage 2 of meaningful use the purposes for exchange are pretty ... in similar categories I think they're for treatment and for public health purposes and the quality reporting pieces of it are really aggregate data, but, you know, given that the current federal law doesn't place any limits specifically on the reasons for which you can query patient data, you know, is there value to taking the recommendations we had done before and thinking about how they apply.

David McCallie, Jr., MD – Cerner Corporation – Vice President

So, Deven?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes?

David McCallie, Jr., MD – Cerner Corporation – Vice President

So, this is David, I wonder if we could follow a model similar to what we did before where, you know, we sort of carved out a well-defined subset called directed push and, you know, clarified that that made sense and was consistent with practice and was implementable and the like. I wonder if there is an analogy here that we could carve out a subset, it's not the whole space, but a subset, common subset of what you might call directed query, just to make up a phrase, where the requesting physician essentially asserts that he has the patient's authorization to fetch the data and that would obviously require a trusted relationship amongst the parties but that's true I think of all of these exchange models.

So, the physician says, I have the patient's permission to request this data from you and the remote responding system would trust that authority, you know, would trust the assertion that the patient has that permission and would release the appropriate information. And so it's a limited subset it doesn't cover the, you know, in case of emergency, unconscious patient and the like, it doesn't cover aggregation for other purposes, but it does kind of cover the inverse of our directed push model which seems to be a very common use case.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right, although, I think, David, even by the way that you phrased it you presumed that we would recommend consent in a directed query model, whereas, I think I would argue actually that one could certainly take a look at the recommendations that we made previously and say, in such a circumstance as long as the record holding institution still has the decision making authority about whether or not to release the data to the particular requester who you presume is attesting to a treatment relationship with the patient you wouldn't necessarily need consent because that decision making, you know, the foundation of the patient's provider relationship exists you still have the record holder as capable of making, you know, decisions about whether to release or not meaning we would not, you know, one could argue that you would take our recommendations and say additional consent to get those records wouldn't necessarily be required unless of course you're operating under a pre-existing legal obligation to get it.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Well, so, I'm trying to go one step further for the case where... I think what I'm trying to do is, what I want to do, let me back it up and try again. I want to put the full authority for release of records in the patient's hands at the point of care and the assertion from the requesting physician that he or she has the patient's permission to have this request fulfilled would trump any existing constraints on the receiving system.

Paul Egerman – Businessman/Software Entrepreneur

So, David, before we go there, let's go to the next slide and think about how we want to structure this discussion.

David McCallie, Jr., MD – Cerner Corporation – Vice President

How we're going to what?

Paul Egerman – Businessman/Software Entrepreneur

Okay.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well I only, so, David, I think what you're doing is actually suggesting a policy direction that I think is worth considering, but it arguably is not exactly a reversal of what we said previously but it's an augmentation of what we said previously, right?

David McCallie, Jr., MD – Cerner Corporation – Vice President

No, in my opinion it fills in the gaps and it's consistent with what we said, but I'm happy to wait and see where you're taking us in the discussion here. I thought you had asked the question, but go ahead.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah, no, we should be on slide 12, my apologies; I seem to have an inability to be able to at least, at present, be able to log back on.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Deven, this is Judy and I have a comment about what you and David were just saying, but I don't know if you want me to wait until you're done this next slide.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah, let me, just ... Paul I think is trying very hard to keep us on a course.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Sure.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Which I appreciate him doing, because we otherwise I think could get twisted up in a million knots in this conversation.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Okay, so give me a call back when you're ...

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Oh, I will, I will, absolutely, Judy.

MacKenzie Robertson – Office of the National Coordinator

Sorry, this is MacKenzie, I'm just going to interrupt one time, whoever has their computer speakers on could you please mute your phone because we're getting some background echo. Thanks.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

So does everyone have, thanks, MacKenzie, slide 12 up which is, you know, sort of the initial set of questions that we teed up for discussion, which is, you know, are we looking to make any revisions given where we ideally would want to head on query policy and maybe David quite frankly maybe your suggestion really does fit well into this question.

And then do we really want or need to make any comment around the intersection of the particular technical model that is in the Request for Comment currently and our previous recommendations on consent or any modifications that we're thinking of making about those recommendations.

So, there are other slides in the deck, but they are the slides that I wanted to hold in reserve, they are the slides about how the DURSA handles query and they are the additional information on the confidentiality codes, I'm not going to go into the details of those; they are there if we need them in order to answer some questions that come up in our discussion.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Did you send out a copy of this deck? It wasn't in the meeting materials e-mail; it might have come out separately.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

No, it should have been in the meeting ... well, okay, not with the original save the date for this...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

No, I've got one that's got the agenda and a Word document about responses; it doesn't seem to have a PowerPoint deck in it though.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

You should have received an email this morning from Caitlin Collins or the Tiger Team; I know there's more than one meeting going on today.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay, so I'm apparently looking at the wrong e-mail, sorry, I'll find it.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

That's okay or maybe it came from ... I'm just looking to see who sent it this morning.

John Houston – University of Pittsburgh Medical Center

It came at 8:36 under ONC FACA meeting.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah, so ONC FACA meeting at 8 ... yep, it hit my box at 8:35 a.m.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I got it, thanks.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay. All right, so frankly, I think in terms of sort of the questions that are on the table there, David, your comment is completely ... I think fits into what we're trying to resolve here. I just want to pause of a moment and get to Judy's comment and then we can move on from there. Go ahead, Judy?

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Sure, as I understand it you and David said two different things.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

You were saying that when it's directly from one healthcare organization to another that you don't need the patient's authorization and David was adding that you do need it and I think that your version matches more what is done today, which is people often in advance of a meeting, of an appointment will contact the other organization for the information so they can take appropriate care of the patient. And, I think that David's proposal is a reasonable one that people might want to add, but I hate to see it as a requirement. We're seeing more of our customers not go that direction and I think it's better the way you said it Deven.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

So, I think the basic – so, in terms of sort of where we were on directed exchange, I think David is exactly right that we, you know, presumed more of a, I know some of the technologists on the phone don't like the distinction that we lawyers tend to make between push and pull, but in a circumstance where it's the record holder directly sending a record to another institution there in the decision making, they're making a decision I'm going to send the record to that person and on some level that's sort of holding of that decision making authority in a kind of push it out the door type of scenario, was that one that we said you don't necessarily need to have the patient's consent unless the law otherwise requires you to do so, we're not going to layer any additional requirements onto that.

But, when that decision-making capability is not there that's sort of, those were the models that caused us to say, look the patient should have some choice about whether their data is in it or not. Now, one could see a...you know, that a push can in fact be a response to a request or a query, right? With the...so, either I push it out on my own, as my own decision as a provider or somebody asks me for it and I say "oh, yeah I'll send it" and that retains the decision making capability and to me is no different really from the model that we initially said didn't necessarily require patient consent, above and beyond, again what the law currently requires. We're not trying to override current law here.

What would be different of course is if the machine sort of operates automatically and sends the record, in my view, without the decision making capability. David, it sounds to me like what you are potentially proposing is an ability for, if you have a patient consent to release information that the entity, recording holding institution would have to do that in spite if they might not otherwise want to do that.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

And Deven, this is Kitt, when you finish with your comment I do have a comment as well.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, so, if David could just respond to my formulation of what he's proposing, I don't want it to be wrong and then Kitt we'll get to you.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Yes, so I would be – I think that's the best way to say it is that in a trusted network and let's just assume that we have trusted users in a trusted network that we could carve out a subset of cases where the request is delivered with an assertion that either the patient has consented to the release of the record or perhaps to accept Judy's friendly amendment that it is a, you are in an active treatment relationship with the patient and would have rights to see this data under HIPAA anyway, but that that would trump the remote systems release policies, because in effect it's either the patient's expressed permission communicated by the assertion or it is a HIPAA covered treatment relationship, which I guess I'll leave it to the lawyers to tell me whether that trumps the release status of the remote institution, but that is what I was suggesting and Judy's amendment is possibly a carve out if that fits the law.

Paul Egerman – Businessman/Software Entrepreneur

And this ... sorry, go ahead, Judy.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

And, I wanted to add to that, that the decision making process could be the computer system which can check is this patient scheduled, is this patient admitted and can check to see if in fact it is truly a treatment situation and therefore I don't think it requires a human being to check that.

David McCallie, Jr., MD – Cerner Corporation – Vice President

I agree.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

This is Wes.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, go ahead, Wes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Okay, so what I hear is a policy discussion, not a technology discussion, about the circumstances under which the record holder upon receipt of a query could decide not to respond, we don't care whether the decision is automatic or manual we're simply saying what is the policy about responding. We know just as background that in the world today it's very frustrating for patients trying to get their information from institutions who typically site HIPAA as the reason they can't give it to the patient, you know, not sensibly, but they do that. And I think that the original proposal as put on slides and modified by discussions about automatic algorithms and so forth is that there is an option for the record holder to decide not to reply even though it trusts that it knows who the requester is.

David McCallie, Jr., MD – Cerner Corporation – Vice President

This is David; I would say that that would not be the expected behavior that this would be ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

No, that's what I'm saying; I said the original slide said that.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Say what I said and then you said we should take the policy a step further and say there is no policy reason why the record holder can refuse to respond as long as it trusts the identity of the requester.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Well, I think it's, it's more than just the identity of the requester it's an assertion that the request is in the process of care.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Part of the policy change is to ensure that the legal implications of sending that transaction are that the trusted entity that's making the request is making that assertion.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Correct and that assertion could be established automatically as Judy suggested based on, you know, the requesting institutions understanding of who's in treatment relationship, but the remote system wouldn't have access to that information and would just have to trust that the assertion is valid and would respond accordingly.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Or another way to say it, they'd need to have a safe harbor.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

That in making that decision to trust they aren't setting themselves up for liability.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right, so let me jump in here just for a second, because we had a couple of folks who wanted to make comments who we've gone a little bit past that point. So, David Holtzman, did I hear you jumping in? And then I want to go to Kitt.

David Holtzman, JD, CIPP/G – Office for Civil Rights

Yes, thank you very much and I'll be very brief. I just wanted to make sure that the participants considered the circumstance in which the healthcare provider is in an indirect treatment relationship, thank you.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, remind everyone what that means in HIPAA language.

David Holtzman, JD, CIPP/G – Office for Civil Rights

Sure, in HIPAA terms it would mean that the, in practical terms it would be the healthcare provider never lays hands or actually has one-on-one contact with the patient. So, often times there are consulting physicians who only looks at the charts and records to do an analysis or consultation outside of the primary treatment relationship with the physician and often, I shouldn't say often, and we believe that there are times when the patient may not even be aware that this additional healthcare provider is involved in their treatment.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, I think it's important to be aware of that circumstance and make sure that our policy recommendations take that into account, that's helpful, David. Kitt?

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Thank you, Deven, so basically SSA is not a HIPAA covered entity and we do obtain a patient's authorization to release the medical information from treating providers to the agency for the purposes of determining eligibility for disability benefits and what we've been doing, because we've been in production with the exchange or the NwHIN Exchange since 2009, using the query transactions with healthcare organizations to request and receive medical information with the patient's authorization and in addition to the patient query or query for documents and retrieve documents we use the access consent policy transaction which is a query for documents and retrieve documents allowing the responding organization to request the patient's authorization from us.

So, in the current exchange specifications they allow for a pause and review using the patient query called deferred patient discovery which allows a responding organization a decision point if they choose to pause in which the pause gives them the ability to manually review the consent authorization and could even be used for patient matching depending on the match thresholds. What this allows an organization to do is to allow a migration path forward to automate the release of information based on evaluation of the consent authorization standard and manually review it if needed.

So, for our purposes we would recommend that ONC support these standards of specifications but also consider potentially a structured standardized consent authorization document which would allow organizations to potentially automate the release of information based on a standardized authorization language such as what's being used by HL7 Security Workgroup effort using the CDA document to hold the consent authorization. So, I just wanted to share with you the pattern that we've been using.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, that's helpful; I think it's a little ... maybe some of what you've mentioned maybe a little further down the road from the discussion where it currently is, Kitt, but it's still ...

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Sorry.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

And you know, for those who haven't had a chance to interact with Kitt or meet her she is our new representative from the Social Security Administration.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Thank you, sorry to take us off track.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

No, no, no it's okay, we at least have the knowledge that that's out there and that will be helpful as we have our conversation.

David McCallie, Jr., MD – Cerner Corporation – Vice President

And this is ...

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Go ahead, David.

David McCallie, Jr., MD – Cerner Corporation – Vice President

This is David, just, you know, again accepting a friendly amendment sort of so to speak, I think that the, you know, the notion of the query caring and assertion that the patient has okayed this release could take the form of, you know, a standardized consent document if that's what makes best sense. I'd like to keep it even simpler than that, but so be it, it's essentially the same thing is the query carries with it the assertion that they have captured consent for release and that that would trump and maybe there are certain circumstances when you don't even need that, but maybe if you did have that that would always work as, you know, as again as a carved out subset of a very common use case. It doesn't address the indirect provider, that's another story.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right, let's sort of hold off to the side for a minute or a few minutes the indirect treatment relationship issue as well as the sort of what form of consent we would recommend if we even get to that point. I want to first, you know, sort of continue to talk about, David, what you've put on the table because I think it's very interesting and in many ways it takes what we said initially on consent a bit of a step further and one could argue not in a different direction, so I think we were pretty clearly dependent on sort of the doctor/patient relationship as the foundation of trust and the ability for a healthcare provider to be able to exercise judgment in terms of releasing patient records even in a treatment context.

And so, I think what you're saying is that, you know, if that treatment relationship in fact exists and there can be reasonable assurance at a minimum through attestation that it does exist and you've got...or you've got patient consent to release that record that that should trump any qualms of the record holder to be able to release the record and that it should happen as a matter of policy. Is that a proper articulation, too far in one direction or the other? I want to make sure we get this right, because I do...I think it's a pretty important statement that I want to make sure that we're all on board with, because it's arguably different from what we said before.

David McCallie, Jr., MD – Cerner Corporation – Vice President

So, this is David, I think, yes you stated it well.

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

This is Dixie, I'd like to also make sure we don't drop out of this context right now what Kitt was saying about the deferred patient discovery, early on some people were talking about there not being a response or there being a response, I think what Kitt suggested, putting it together was what David is suggesting is if a query is not accompanied by an attestation of a treatment relationship or a consent then they're not being no response but rather that the query response be a deferred patient discovery while these things be, you know, figured out, I like that idea.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

So, I want to understand...okay, so I don't want to drop that either, but that was not ... I guess I didn't fully understand what the deferred period was about, does it only apply when you don't have the attestation of the treatment relationship or the consent or is there in fact a deferred response when those things in fact do come in but the recipient, the record holding institution gets time to sort of evaluate the request or vet the request, Kitt can you just clarify in fact when does the deferral apply?

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

First patient discovery is an option that's given to the organization to review it if they cannot properly automate their process or to review their request, it's often used when there's a question or a concern by the organization and that they can put that in place at any time.

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

So, if they get a request and they don't have – and they're not sure whether they have a consent or whether they're a patient, a treatment relationship exists; does that result in a deferred patient discovery?

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Yes, it can.

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

That's what I was understanding and I think that's a really nice concept that you don't just drop it or you don't just say no but you put it in this deferred state while you get the answers to these things.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Right, so the organization has that option to either automate or do it manually.

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, can you hear me?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes.

Paul Egerman – Businessman/Software Entrepreneur

I'm listening to this discussion and I'm sort of wondering where we're going with it, because we should not, as a Tiger Team be designing how these systems should work, we should be addressing the policy issues. So, the issue is ...

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Paul, we're having trouble hearing the question.

Paul Egerman – Businessman/Software Entrepreneur

The question is from a policy standpoint when is patient consent required.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

Paul Egerman – Businessman/Software Entrepreneur

We should not design how the system works we should simply be asking the question, in a query response model when is patient consent required.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

This is Wes ...

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

Yes, but the RFC does propose a specific process, I thought that we were responding to the RFC.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, that's one model that I think we need to consider, but I don't think it's the only – I don't think we should limit our consideration to only that technical model, but that one should ... since it's in the RFC we should definitely address it.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

This is Wes, I certainly think that what the SSA is doing now is real world experience and we should not ignore it.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes.

Paul Eggerman – Businessman/Software Entrepreneur

That's right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I further think that there is a policy issue hidden in this discussion which has something to do about the timeliness of response. The question seems to be one statement we've had is that as long as you trust that you know who the request comes from you have a safe harbor to trust their assertion of consent or purpose and you must reply. The other point is it says you have time to consider that or even in the real world case, you have time to go find the record. So, I think the policy issue is, is there or is there not the ability to consider whether you trust or is our model that you are obligated to return the record.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah, I think so and in what sort of timing circumstance maybe the other piece of that.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, I think that's important when you get to weeks versus days or months versus weeks, but ...

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Or hours.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah. Well, under a few circumstances and hours, but I think the big problem we're dealing with is people who spend weeks trying to get their data, well the biggest problem we're dealing with is people who spend weeks trying to get their data out of the hospital with...set their leg, you know, or whatever.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Well, if you show up in the ED it's going to be minutes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President

And this is David; the spirit of this is to, again, enable the most common use case to work smoothly and to remove some of the perceived barriers about release of information and response to a query.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President

If we can carve out a subset that's 65 or 70% of the normal case and assure everyone that this is good sound policy to behave this way I think we do a big benefit to the country's health information exchange process knowing full well that there are boundary conditions which aren't covered, but we carve those out and some of those may require off-line out of band resolution, but for the use case where you know who the patient is, you can match them up and you know it's a treatment relationship because the attestation is in the query message and you have no reason not to send it then you can send it in good conscience that you are in fact respecting the sanctity of the patient provider relationship and following the laws of the country.

John Houston – University of Pittsburgh Medical Center

This is John Houston, I would agree with all of that, I think the thing that's missing here or needs to be also added to this then is some way to ensure that the providers that are involved in all of these exchanges are bona fide providers and that there is some way for the provider space to have assurance itself that when they're dealing with another provider that that provider is in fact one that is entitled to or is, you know, one that can be trusted in the exchange.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Yeah, that's a good point.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah, but John, I don't know where, this is Deven, where you get those assurances beyond, you know, we made some recommendations on the sort of identity proofing an authentication piece that we would hope would be sort of followed through, but in terms of the attestation of the treatment relationship, you know, absent being part of a network where you can do something that, like Judy suggested, where you actually can confirm that there's an appointment scheduled or that the person is on the patient list of the doctor who's asking you're going to have to trust their attestation.

John Houston – University of Pittsburgh Medical Center

No, no, no my point is that I will trust...if I know a provider is part of this entire exchange fabric and they have in some way been certified themselves then I'll trust that when I get a transaction from them that it's an appropriate transaction. My concern is that there needs to be some process in place to ensure that almost on boarding of those providers to make sure that when a provider is part of the fabric that we can trust them to start with.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

I'm a little confused, John. First of all, if it's UPMC that is sending the information or is requesting the information first of all you would trust that it's UPMC because there would be authentication or a certificate of authentication to know that it's UPMC and secondly, wouldn't you be trusting that UPMC's system is set up appropriately.

John Houston – University of Pittsburgh Medical Center

Yeah, but that's my point though, is that there needs to be a process in place, because, yeah UPMC is an easy, you know, example, but ...

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Okay.

John Houston – University of Pittsburgh Medical Center

Let's just say there is a Dr. Houston.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

Sure.

John Houston – University of Pittsburgh Medical Center

Now I don't know Dr. Houston from, you know, Dr. Smith.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

You mean within UPMC or you mean ...?

John Houston – University of Pittsburgh Medical Center

No external.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

External okay, yes.

John Houston – University of Pittsburgh Medical Center

Because there are lots of small providers and all I'm asking is that I think we need to as part of this make sure that the providers that are participating in the exchange are some way vetted so that the other providers who may not even know that provider is can have some high level of assurance that it's an appropriate request to begin with.

Judy Faulkner – Founder & Chief Executive Officer – EPIC Systems Corporation

You know, I think you're really hitting on one of the more complex components of this, which is it's not as much, I think some of what we've been discussing so far it is just what you just said, how does that individual, the two doctor clinic get a certificate of authentication, get validated as being appropriate for all this?

John Houston – University of Pittsburgh Medical Center

Yes, that's what I'm trying to say, exactly.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

That's why I've been careful to stipulate that in talking about policy is because I think it is an issue that there are attempts on the table to solve now but we have no proof yet that they're practical. I mean, it's easy to authenticate the Social Security Administration, it's harder to ...

John Houston – University of Pittsburgh Medical Center

But shouldn't we make it part of our recommend at least that something like this has to occur in order to make this work.

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

Yes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Well, that's why I included that language whenever I was describing it, because I think it's absent that extra part the whole thing falls apart.

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

Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President

And this is David, I predicated my comments with assuming that there's a trust framework in place, so I totally agree with John's point it's got to be there and that's the hard part. There are precedents for this in that Surescripts works that way and that a certification process of becoming a client of Surescripts you have to go through and are contractually bound to respect certain behaviors and there is certain proofing and validation of the physicians that join that network, and they then assert that they've captured the patient's permission to request the prescription information and the PDMs agree to honor that, and it obviously scales pretty well. This is a little bit more complicated in sensitive data but I think that model has proven to be workable.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

And it's entirely consistent with what we have envisioned as the roles of HIOs in the past and I believe the work that's going on now to create a mini DURSA for HISP is also based on that being a requirement right? Of a HISP has to do some, I always forget the word, vetting of its members.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Yes.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, I mean, I'm not aware of, this is Deven, I'm not aware of sort of the progress of those discussions and who's having them and where they're going, but it does seem to me that all comments of maybe the last 5 minutes seem to presume that query would take place within some sort of ... in some sort of organized fashion through some sort of network that someone is sponsoring, right? That it's, you know, it might be a vendor sponsored network, it might be something like Surescripts, it might be an HIO that's regional or state-based, but that somebody's standing up the query capability and is sort of responsible for vetting the participants, you know, making sure that they have appropriate credentials and that they've signed on to whatever the rules of the road are for that particular network.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Deven, this is Kitt Winter again, I was wondering as we spoke earlier about patients and provider identity in previous conversations, do patients have a voice here to indicate the relationship that they have with the providers that could be checked as we move forward?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

You know, Kitt, that's a good question. You know, certainly I would think that if a piece of David's proposal that involves, you know, when the patient has actually consented to the release of the record would be a mechanism for indicating, you know, that the patient has essentially said, I want to release the record to this person. Am I right, David, about that that's a way for, you know, if in fact it's the patient not through the transmit function, but by asking her provider to go get her records from UPMC for example that that creates the link?

David McCallie, Jr., MD – Cerner Corporation – Vice President

Yes in the simple model that would create the link. I think that there would be an evolution of this model in the broader picture that would support other ways to capture sort of standing authorizations that would allow say support for emergency room use or something that maybe goes beyond the simple directed query, but I'm purposefully holding those, you know, as not covered by the simpler use case.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay.

David McCallie, Jr., MD – Cerner Corporation – Vice President

I think that the simple case is if you say to your provider I want you to go fetch my records from UPMC because they've been taking care of me before I moved to Kansas City then that should happen, because you gave them permission to do so.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President

And it shouldn't be much more complicated than that from the patient's point of view in keeping with our no surprises model.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right, right.

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

You know, this is Dixie, I know that David said that, you know, in his carve out statement he said that this is a trusted network, but I don't think he meant trusted network in the sense that you did, Deven. I mean, it could still be a request between a Direct user, it could be, you know, it could be the query ... it could be conveyed in a request using the Direct protocol where the person isn't in a, you know, trusted network beyond using Direct. Right David?

David McCallie, Jr., MD – Cerner Corporation – Vice President

Yeah, this is David, I mean, I wasn't contemplating that, but I think that that assertion that, you know, I have permission from the patient for you to release to me via Direct a copy of their records it would work the same way it's just an asynchronous existence.

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

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Well, the question is not ... the question is does the record holding provider have a reasonable basis for believing that the entire transaction is not bogus.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

And that gets down to either some level – I mean, there is an intermediary for Direct with is the HISP but Direct transactions can go from HISP to HISP right?

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

Yes.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

So, I think first off we should close off or we should be willing to work on the first questions at hand just stating an assumption about the ability to trust the identity of the requester.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

And giving examples of why you might be able to trust it and then we should decide do we want to go more into the issues around that.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

This is Kitt; another question is how would the provider know that another provider has that relationship with the patient when you're talking about that?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

All they need to know is that it's a legitimate provider and it is saying it has the relationship with the patient.

David McCallie, Jr., MD – Cerner Corporation – Vice President

That assertion has to be a scary thing to make, because if you make it you expose yourself, you as a provider expose yourself potentially to, you know, legal challenge, in other words you're going on record in a binding way and saying you have that relationship with the patient and that's the way Surescripts works. I mean Surescripts trusts the users of the system that when they send a query into the Surescripts pub that they have in fact captured permission from the patient to do so and if somebody is caught doing that without permission they're going to get in trouble.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah.

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

Yes.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Within whatever authority Surescripts has, right, which is you can't use the network if you violate the policies.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Correct.

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

Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President

It's contractual as well as whatever HIPAA issues might be brought to bear or state issues on top of that.

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

And the same thing if you use a Direct transaction, you know, we trust Direct addresses, you know, we can assume that their identity has been ... they've been identity proofed, they've been given a certificate, all that's been done, but I don't think we need to go the extra step of saying, well it's a known network that they're in, it's just that for various reasons we have reason to trust their identity.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yeah, I mean, I think this all comes down to risk analysis on the part of when setting up approaches by the record holding provider, they're going to decide, they're going to trade off the risks of responding versus not responding just as they do with anything else they do. And they're going to evaluate the credibility of the mechanism that brings in the incoming transaction. I mean, they're already willing to accept faxes.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I mean, it's not like they need a high level of credibility, but ...

David McCallie, Jr., MD – Cerner Corporation – Vice President

As long as it's on letterhead though, right Wes, it's got to be on letterhead.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

It's got to be on letterhead, yeah, yeah.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right, well, you know, one of the ... so that makes me wonder whether it's useful to sort of get a more ... to at least look at how they do handle this in the DURSA and whether that ... whether the way that they've approached it is a helpful way for us to think about it, although in many respects it's a little bit different. So, I have the slides up on my computer but I can't control them, which is probably just fine. Can we go to slide 13?

Okay, so as I mentioned earlier the DURSA is an agreement that gets executed by participants in a network called eHealth Exchange that used to be called NwHIN Exchange and they have a term called a submitter which is any participant in this network who submits a message to another participant like a query for records for example, and those submitters are responsible for, among other things, representing that the message that the request is for a permitted purpose and is supported by legal authority including any consent or authorization that might be required.

Next slide, slide 14, now if you are getting this message from a submitter and you are also in the network if you've agreed that you want to be able to query for treatment information you are required to, as a condition of the DURSA to respond to any request for information for treatment by either providing the information or providing a standard response that the information is unavailable or cannot be exchanged, which means that actually under their agreement they do allow participants to retain the right to determine when to release information per whether it's per applicable law or even their own local policies.

So, the way that this has been described to me previously is that you have to answer anybody who knocks at your door but you don't necessarily have to provide the information that's requested even if it's a request treatment purposes, but they do include the information about needing to represent that the particular query is for a purpose that's permissible either under the law or per the DURSA and has any consent that might be required that the requester is aware of.

So, we've been told that we could get additional information on the reason why they landed on this particular policy and any other components of it, but just for purposes of sort of continuing to think through the recommendation on the table and further flushing it out I thought it might be helpful to sort of hear what they're doing in this particular circumstance.

Judy Faulkner – EPIC Systems Corporation – Founder & Chief Executive Officer

This is Judy and some of our customers have asked for this almost always it's for reasons of profitability and desire to exchange with some and not with others to create their own organization within the group of people that they exchange with and our take on that has been it is the patient's choice and you should not be doing this simply because you don't want the patient to go to that particular healthcare organization.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

And this is Kitt, I know that SSA had commented on this, but we have seen organizations have issues with applicable laws and local policy for this not just by the patient's choice, an example is that we've seen limited release or no release of information for minors or potentially sensitive documentation. So, it's not always at the patient's request.

David McCallie, Jr., MD – Cerner Corporation – Vice President

This is David, I didn't bring up the sensitive and minor notions in my original pitch, but I think that has to be accounted for.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Again, I'm working on the 70% common case and we have to define the boundary conditions and, you know ... protected entities and other sensitive information entities may need a different carve out. So, I think that's not a ... it doesn't mean that it wouldn't work, it does mean we have to account for those boundary cases.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

I'm not sure my question is relevant, but I wonder if I can ask Kitt, does that mean that people applying for disability benefits for someone under 18 has no way to get the information to the Social Security Administration?

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

No, it has to do with disclosures through eHealth Exchange. A number of locations had things written into the policy that they would disclose to SSA the paper documents but they haven't addressed that issue through electronic processes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I see, thank you.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

So, SSA has always received the information through the paper process or, you know, through the processes that we have in place with fax and ...

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, I got it, thanks.

Kitt Winter – Social Security Administration – eHealth Exchange Coordinating Committee Chair

Okay.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

That's helpful. So, what it sounds like is that we are, you know, we're coming to some initial consensus potentially around what, I like David your term for it, sort of the 70% solution where you're talking about adults, you're talking about non-sensitive data, not that all health data isn't sensitive, but the categories of data of uber sensitivity and particularly where you have, you know, institutions where that's sort of their primary type of care that they provide or it's a well-known type of care that they provide, but that in the 70% sort of category when you have the appropriate processes in place for sort of vetting participants whether it's through the issuance of a Direct address or through participation in a network where there's some vetting as to ID proofing and credentialing, if there is a query that is for treatment purposes you've got either the attestation of the provider that there's a treatment relationship or you've got the patient consent, or you've got both of those things then the responding institution, the record holder should be required to send that data.

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

You know, this is Dixie, I was just thinking about, you know, the policy that's always relevant is the policy of a sender not the recipient. So, I think we've got a problem here, because it's possible that someone who requests the data, in fact it's very possible, that their consent, in other words, patients give consent at every single place that they go and that the consent that they give may not be the current consent that the patient wants, I know we discussed this earlier, but the predominant policy ruling is that of the sender not the recipient.

So, even if a requester comes across and says, "Yes, I have the patient's consent to receive that data," the sender still needs to check their own consent and their own local state policy before they actually send it. So, I don't think we can say that just because the request is accompanied by patient consent or recognized treatment relationship that they must respond. There "must" is really still attached to their local policy and their local consent, and their local, you know, state law.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Yes, but we can say that absent other legal barriers.

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

Legal and consent, if they have, if the recipient has a consent on file from that individual and that individual says no I don't want this, I don't want my information shared with Dr. So and So or with a particular health system, I won't even use an example, if they have something like that on file they still can't release it.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well but wouldn't that – I mean, I get what you're saying Dixie, that the disclosing entity has to, if they've got a contrary patient consent on file or the consent that's presented by the querying institution doesn't have the right language in it that matches what the recorder holder's needs are in terms of say there's a state law.

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

Right, if there's a state law.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right, but would that then not prompt, per the spirit of where we're trying to get here, a requirement really on the data holder to or both institutions to resolve any conflicting consent or to try to get the appropriate authorization to the disclosing entity.

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

That's exactly right, that's what I think we need to add.

John Houston – University of Pittsburgh Medical Center

But how does the recipient ...

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

You can't just say because the request is accompanied.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Right.

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

They have to give the data; we have to also say that the sender also, you know, has to check their own local law and their own local consent.

John Houston – University of Pittsburgh Medical Center

But let me, how does the – hold on, how does the sender know that the recipient's consent that they have in their possession, you know, we're talking about this model whereby the recipient or the receiving entity could attest that it has a consent, how can we make sure that the authorization is sufficient under the other entities laws if it's in another state?

Deven McGraw, JD, MPH – Director – Center for Democracy & Technology

Well, I'm not sure that we can absent knowing ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

That's part of what you're ... that's part of what you're trusting the requester to do.

John Houston – University of Pittsburgh Medical Center

But the requester isn't necessarily going to be an expert on that other state's consent.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

No, no, no the requester ...

John Houston – University of Pittsburgh Medical Center

Oh, I'm sorry ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

The requester says, legally says, "I have consent in my state; it's valid in my state to get this specific information."

John Houston – University of Pittsburgh Medical Center

Yeah, but it's the sender's state that is the one that matters in terms of disclosure.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Are you talking about the record holder's state?

John Houston – University of Pittsburgh Medical Center

Record holder, yes.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

That's right; the record holder always has to evaluate every request for information from anyone according to the rules of their state. I mean, that's true now, it continues to be true.

John Houston – University of Pittsburgh Medical Center

I understand that but how do they qualitatively know that that's sufficient or not?

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

How does who qualitatively know?

John Houston – University of Pittsburgh Medical Center

The discloser or the sender when he's dealing with it...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

When you say the sender you mean the record holder?

John Houston – University of Pittsburgh Medical Center

The record holder.

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Because you send a request and then you send a response, so it's confusing.

John Houston – University of Pittsburgh Medical Center

Sorry, the record holder in one state is responding to a requester in another state and the requester in the other state is saying, "I have appropriate authorizations" qualitatively, you know, the consent requirements in one state may vary based upon this ...

Wes Rishel – Gartner, Incorporated – Vice President & Distinguished Analyst

Right, so each party is responsible for understanding their state.

David McCallie, Jr., MD – Cerner Corporation – Vice President

But aren't there states where the patient's request would not trump?

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Well, the disclosing entity would absolutely have to have ... if in fact there is an authorization requirement in their law that it has to meet certain parameters then the disclosing entity would in fact have to examine the authorization that the patient gave at the requesting end before they could release it, but that sort of seems like a kind of a give and take that we might, and now I'm realizing that we're reaching sort of the end of our call, we might have to pick this up for further discussion on our next call in addition to further discussion of issues involving form of consent and timing of response, and things of that nature. Are folks okay with sort of ... we really are kind of forced by our time constraints to sort of put the rest of that stuff on the table in addition to we will work with staff to articulate where we think we got today so that we can refine it and build on it on our next call.

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

Sounds good.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, so, I think we need to open up the lines for public comment, MacKenzie?

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Sure, operator can you please open the lines?

Caitlin Collins – Altarum Institute

Yes. 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.

Deven McGraw, JD, MPH – Center for Democracy & Technology – Director

Okay, thank you all this was an incredibly interesting call. We'll be back on this topic on our next call which is coming up later in the month and we'll let you know how well we do with the patient ID proofing and credentialing recommendations tomorrow at the Policy Committee. Does anybody have anything else they want to add before we close? All right, thanks, again, talk to you all soon.

John Houston – University of Pittsburgh Medical Center

Thanks, Deven.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everybody.

David McCallie, Jr., MD – Cerner Corporation – Vice President

Bye-bye.