

**HIT Policy Committee  
Privacy & Security Tiger Team  
Transcript  
February 4, 2013**

**Presenation**

**MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good afternoon everybody, 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 & Security Tiger Team. This is a public call, so there will be time for public comment at the end of the agenda. It is also being recorded, so please identify yourself when speaking. I'll now do 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 Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Dixie. Neil Calman? Judy Faulkner?

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Judy. Leslie Francis?

**Leslie Francis – University of Utah School of Law – National Committee on Vital and Health Statistics**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Leslie. Gayle Harrell? John Houston?

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

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. Micky Tripathi?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Micky. Latanya Sweeney? Kitt Winter?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Kitt. And any ONC staff on the line, would you please identify yourselves?

**Kathryn Marchesini – Office of the National Coordinator**

Kathryn Marchesini.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Kathryn. And I believe we have David Holtzman...

**David Holtzman, JD, CIPP/G – Office of Civil Rights**

Hello.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks David. Okay, with that I'll turn it to you Deven.

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

All right. Great. Thank you very much MacKenzie. What we are going to do today is to try to make additional progress on our discussion about policy issues for query response models for health information exchange. We've had a couple of previous Tiger Team meetings on this so our hope is to both sort of go over our attempts to articulate where we think we landed in some previous discussions, do a gut check on those, make sure that everybody's comfortable with where we're headed. Continue to try to surface open issues and tackle them, all with the goal of being able to present a set of recommendations, ideally in March, to the Policy Committee, at a minimum though; I think we've known all along we wanted to try to wrap this up during the first quarter of 2013.

So what I want to do is, do a quick kind of overview of where we think – where I think we are, and that means I'm going to go through several slides, just as a way to kind of kick-off the discussion. I would prefer, if possible, to be able to just give that overview quickly, without necessarily stopping for questions. Because I think sometimes we start to get questions on issues that are covered in later slides, and my ideal is to sort of get to a sense of sort of where we think we're headed. But of course, to go back, challenge assumptions that have been made on the slides that maybe we thought we were further along than we were, or to get to people's questions. And I think that this is particularly important both because the topic that we're handling is a hard one, but also because I think some of the issues that we're grappling with did come up in some of the testimony that was presented as part of the Health Information Exchange hearing that was a joint hearing of the Health IT Standards and Policy Committees that took place last week. So, I think some of what we learned in that hearing is going to be relevant for some of the discussion that we have today. But I do think it's important for us, just in the first five minutes of this call, to sort of quickly get through kind of where we think the discussion is heading. Again, we will come back and reassess those assumptions, challenge where we're heading, all in an effort to try to finalize these. But I guess I'm sort of admitting that I was slightly frustrated on our last call that we maybe were a little ... some of the questions that came in, came in early and were clearly folks are thinking about this a lot in the time that we're spending together. But sometimes I recognize that not all of you have a chance to review the slides before the call, and you don't necessarily know that topics that you want to interject are coming.

So with that, I want to say again, we are focusing on query for what is comparatively a simpler set of issues involving querying for records. It's querying for treatment, it's dealing with adult patients and it's dealing with information that isn't necessarily, that is still sensitive health information, but doesn't fall into the highly sensitive category like genetics, HIV, reproductive health or mental health. The idea is to try to solve for that relatively simple ... or comparatively simpler use case and then come back and pick up the more challenging aspects of it and see how those recommendations apply when the use case gets a little more difficult. We assumed that there would at least be a trust environment in place to at least vet the identity and authentication of the provider who's making the query; either through the use of direct and the issuance of a direct certificate, or because the person has a membership in a trusted network like a state health information organization where there's some vetting and issuance of credentials that takes place.

So again, with those assumptions, we were reaching the point where we said, look, if there's a query that's being made for treatment purposes, at least one of the following has to be provided. An attestation from the requesting, that the requesting provider has established or is in the process of establishing a treatment relationship with the patient who's the subject of the information that their requesting and, in fact, is authorized by whatever relevant law that exists in that provider's jurisdiction to be able to access the information. Or there's a valid consent from the patient. Now it says authorization on the slide, I think David Holtzman from the Office for Civil Rights pointed out to us that sometimes, that we want to make sure that we're clear, we're not talking about a valid HIPAA authorization here, because we're really talking about request for information for treatment, where an authorization under HIPAA is not required. So, in some respects this is really talking about, you have the patient's consent to ask for this information. And so at least one of the following would be present, and in many cases you would have both, the consent from the patient.

And then in terms of sort of what then the data holder on the other end of that query has to do. If in fact, what you're getting is an attestation of the existence of a treatment relationship and that you have the legal authority to ask for the information, then the data holders are expected to at least acknowledge or respond in some way, that they've got the query. And, there's another slide about what the content of that response is that in fact I think we need to talk about in some more detail, because we really didn't get to cover it much. If in fact what you've got is a valid assent or consent release from the patient, then the providers who are the data holders, in fact should be expected to provide the information that's requested, absent of course, a legal requirement that would restrict or prohibit that release. And certainly in both circumstances, the data holders who are responding have to consider local policy, ethical principles and applicable legal requirements.

And so what we were trying to do on this slide was to capture the essence of some conversations where there was a sense that people were feeling very strongly that when the patient specifically agrees and consents to the query and the release of information from the data holder, that the response of the data holder really should be to release the information. Consequently, if that's not part of the query, but instead the query is based on attestation of treatment relationship, that maybe the response that should either be required or recommended might be slightly different. We will talk about this during this call today, because that is a sort of distinction that I think we want to make sure that we are in agreement with.

So again, when the data holder gets the query, what's the response when what you've gotten as part of the query is the treatment attestation and the attestation of legal authorization to get those documents.

So, how should the data holder respond? Certainly, there is always the option to respond with the information that's requested. But what if there is some hesitancy on the part of the data holder to release the information for some reason, is there some sort of response or acknowledgment of receipt of query that we would want to see be sort of the default or the minimum response that a data holder would have to give. And one of the other things that we had talked about was that data holders would maintain an accounting of tran-, of query transactions, including ideally the authorization or attestation provided, and then make these available to the patient upon request. This is another one that we have talked about in a tertiary way in previous conversations, but haven't really drilled down on in some degree of detail.

Another thing that I think we need to sort of pin down a bit is what's the timing of the response. We were reluctant to say that the response would have to be within a specific time deadline, given variations in technology and workflow. One of the other issues that came up at the hearing and sort of subsequent conversations that I've been having with folks at the Social Security Administration is, do you at least allow for some automation of response that includes a sort of automatic response, in certain circumstances, or a pause and review, which enables the data holder to sort of review the request, might be frankly helpful in patient matching, circumstances where you have more than one record that matches the query, at least based on the initial information that's provided.

And then I was thinking of a few additional issues that occurred to me in sort of thinking this issue through some more and some of the issues that were raised in the exchange hearing, and that is, when you have health information, maybe I should have said HIO here, a Health Information Organization where the patient's been provided the opportunity for meaningful choice in the way that we recommended about whether to participate, is that really sufficient in terms of sort of the consent to release the information in response to the query, as long as again the consent meets any applicable legal requirements, if they exist, for release of the data. On our discussion about sort of keeping an accounting of queries and what information is presented as part of the query and what's the response to the query. Is this possible to do in a direct disclosure, where this is not through the HIE, where we're relying on existing electronic medical record technology that might, in fact, not distinguish when a disclosure is made between one that is prompted in response to a query and just a typical record access done through like an audit trail, for example.

And then in terms of the types of queries that we want to either recommend, encourage, should queries be capable of being directed only to those entities where the querying provider believes specific patient records exist, such as by asking the patient where they have received care previously, or limited to local geography. And if so, what about emergency situations, because I've certainly heard of sort of networks and query capability where the ability to sort of query the entire network isn't necessarily present, there has to be some decisions made at the front end about whom to ask. But I recognize that that's, that does provide some protection around, from a privacy standpoint, one could argue in terms of the queries that go out the door, but may not be as workable in emergency situations. So, I'm going to stop, because I've just been talking a lot and I want to thank all of you for allowing me to sort of paint the big picture of the discussion that we've had to date and the issues that we need to discuss. And I'm sure there are sort of lots of questions prompted and thoughts and I'm eager to hear them. Thank you all very much.

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

This is David, I'll get in line.

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

Go right ahead. In fact, you can go first.

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

I appreciated that you would attempt to clarify the distinction between attestation, authorization, consent.

**MacKenzie Robertson – Office of the National Coordinator**

Hey David, this is MacKenzie, are you on a speakerphone, or could you pick up your handset, because there's a really a big echo.

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

Oh, I'm sorry. Is that any better? I'm on a blue tooth and I don't have a ...

**MacKenzie Robertson – Office of the National Coordinator**

Not too much better.

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

Okay, hang on a second.

**MacKenzie Robertson – Office of the National Coordinator**

Better.

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

That was better.

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

Okay, maybe if I back – I think it was reflecting off the screen, I'm sorry. Okay, so Deven, I appreciated the attempt to clarify the difference between consent, authorization and attestation, but it left me a little bit confused ...

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

Okay.

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

... and at a minimum, I'll make my suggestion before I ask my question, which is, we ought to put some definitions of those things in these slides at some point...

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

Sure.

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

... just so that when we use those words in the subsequent slides, they're not ambiguous. And if I understood you correctly, and I've heard you say this before so I think I've got it, if it's a direct treatment relationship, then expressed consent is not required, in which case it sounds like the requesting system, if it's sending an attestation that this is a direct treatment relationship, are we saying that we don't think any additional consent need be transmitted besides the attestation of the direct treatment? Or is that up for discussion.

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

Well, I think it's up for discussion.

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

Okay.

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

I think initially when we were sort of coming at this issue, we were thinking of what's the...what are the sort of minimum requirements of a querying provider, in terms of sort of what they have to demonstrate to the data holder, in order to justify a release of the data. And you are absolutely right, assuming that there's not an additional legal constraint where the patient's consent or authorization might be required, certainly HIPAA, operating as a baseline, would allow for that data to be disclosed for treatment purposes. And so the consent isn't required. But previously we had sort of, in trying to create the sort of moral equivalent of the safe harbor, where we would – situations where data holders really should respond, there seemed, people seemed to be coming in the direction of, well certainly if you have the patient's consent, even if you don't legally need it, you've sort of got the patient essentially asking for that information to be shared. And in those circumstances, really the data holding providers, again absent a legal constraint that would either limit what they could disclose or prohibit it, that they really ought to share that information. Not that they couldn't do it with just a mere attestation, assuming no other legal constraints beyond HIPAA, but that certainly in a circumstance where there is additional consent provided, to sort of bolster the need for the data or to demonstrate that in fact this is something the patient really wants, that that should prompt a response with data, as opposed to just a response, well yeah, I got your query, but I'm not going to release it for some reason.

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

Is it worthwhile asking the edge case under HIPAA, can a patient cordon off some of the information to the treating physician, can they unconsent, can they deny access?

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

So, there is the right to not have your information sent to a health plan, but in a treatment context, what you have is the right to object and to ask that information not be shared for certain reasons for which it's permitted, but the covered entity is not under an obligation to honor it.

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

Okay.

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

I'm going to stop for a minute and make sure that I've phrased that correctly. David Holtzman?

**David Holtzman, JD, CIPP/G – US Department of Health & Human Services, Office of Civil Rights**

Hi Deven, thank you. It's called – we term it a request for restriction.

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

Thank you.

**David Holtzman, JD, CIPP/G – Office of Civil Rights**

But other than that, you got it perfect.

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

Okay. Yes, you're right, right to object is something different.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Deven, could you say that again please.

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

Go ahead David.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Oh no, not what David said, but what you said that David said you got right.

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

Oh. Okay. So when you are, if you ask, it's called a right to ask for a restriction. So if I as a patient said, well, I want you, I'm okay with you sharing my information for treatment purposes with these two providers, but not this other provider, right. That's asking for a restriction on disclosure that would otherwise be permitted by HIPAA. And the patient has the right to ask, but the entity doesn't, is not obligated to say yes. And probably, in fact, shouldn't say yes if they can't honor.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Good. Because any entity I know has said, they can't do that.

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

Well...

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

Because they say, okay, there are two OBs, there are three OBs and you're saying one of the OBs can't share, but that might be the one who shows up when you deliver that baby.

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

Yeah, this is Wes. As I understand, that restriction comes up in the context of signing your initial HIPAA consent and the understanding is that the provider has the ability to say, if you put these restrictions, we won't treat you.

**David Holtzman, JD, CIPP/G – Office of Civil Rights**

That's actually an area that could cause problems for an organization. Under the privacy rule, an individual patient at any time may make a restriction and if there is a – if it is clear that the provider has retaliated against an individual for exercising their rights under HIPAA that in itself is a violation of the privacy rule.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

So are you saying that it's okay for them to say, we can treat you, but we can't honor your privacy request

...

**David Holtzman, JD, CIPP/G – US Department of Health & Human Services, Office of Civil Rights**

Absolutely.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

... versus we won't treat you. So some customers I see even have ads that say, if you join us, all of our doctors share, and that's in their information. So you're saying that's okay.

**David Holtzman, JD, CIPP/G – US Department of Health & Human Services, Office of Civil Rights**

Sure. So, let's step back a moment. The privacy rule does not interfere or take sides on an individual practitioner's choice or a patient's choice, to choose who they wish to have involved in their care and treatment. However, if there is a direct connection, in other words, an overt disclosure that should you choose to take advantage or do something under the – that you're guaranteed under the privacy or security rules. If you take that action, we will drop you like a hot potato. That could lead to allegations of retribution or ... for exercising their rights. The other context is that providers have been working with this for a number of years and they take these requests and so long as they take the request and review it, and then provide a response, they have fulfilled their requirements under the rule. It's when they don't have a process for review or they accept the restriction and then don't honor it, that leads to issues and concerns. Thank you.

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

This is Wes. We're talking about disclosure here ...

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

That's right.

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

... to another organization ...

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

Yes.

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

... as opposed to, sharing within the organization, right?

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

Well, that's right, but I think that where these questions are headed is if the, if since having the patient's consent to release information is part of the query is one of the circumstances that we've laid out as being able to accompany a query. I think what David and Judy were sort of probing on is whether the patient's response could be well okay to this provider and that provider, but not everybody, right.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yes.

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

So, it then has an impact in terms of whether the recipient data holder, you know, how they respond.

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

So, in the – just to be clear, if a partnership has several OBs, the patient doesn't even have a right to ask that one of the obstetricians not receive the data in the partnership, but the circumstance we're describing here is an over-request that either asserts that this is for treatment or contains a specific authorization statement from the patient. I don't ... so, and I'm trying to relate that to this discussion about ... I mean, if there is an authorization request, then it's just illogical that their authorization request could be, the authorization statement could be, I don't want you to give it to this provider, right, that would be a de-authorization or something.

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

Well, that's right, but I think we are talking about the, we're talking about sort of two ends of the transaction, right. What does the querying provider have to present and then what is, what should be the response of the disclosing provider when you get a query. And on the front end, I think we've said at a minimum you have to at least attest, and if we're assuming a use case for treatment. You have to at least attest, or if you're in a situation to be able to provide proof, like a network where you can actually demonstrate that you have a treatment relationship with the patient, that has to be sort of part of what gets presented to the data holder. And ideally, to address concerns that Gayle has raised about having the authority to be able to get the information. But, it's, that its information you have the, you can request, as part of your professional certification or what have you ... could span a number of boundaries. Then on the other hand, then what does the data holder have to do in response. And one of the things that we had talked about previously and maybe we're coming around to say that this issue isn't necessarily one we want to emphasize. But certainly in previous conversations, it was our sense that when you had both the treatment relationship and, by the way, you also had some sort of consent or assent or approval from the patient of the release of that data, either through something that's general or something that's very specific, and relevant, but at least covers the query, that you would, there would be an obligation to respond. And that maybe that response would be stepped up and require the actual release of the information, if in fact, it was something that the patient – there was indication that the patient wanted it to happen.

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

I guess my question is how general, in the following sense. We're talking about the scenario where request comes from a treating provider to a record holding entity ...

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

Yeah.

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

... and the – are we saying that the positive affirmation, whatever it's called, of the patient's desire for this information to be transferred, identifies the treating provider or are we saying I'm the emergency department and I have an assent here from the patient that says they want their information to go to whoever. I mean ... I'm just trying to understand what is this assent to, is it assent to transfer to a specific provider or is it assent to transfer to any provider.

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

Well, I think it's an assent that covers the request that's in the query, at its basic level. If we wanted to be more specific about what we thing ought to be required, if in fact it's tied to a recommendation that the information actually be released, then we should talk about that. But again, I think we were being pretty basic here, we certainly have been to date, which is to say that the law at a minimum suggests, implies, requires, that if in fact the justification for the release by the data holder is treatment, then certainly the query ought to have some indicia of treatment in it, attestation being the one that works, particularly when you're in separate networks and you can't check. But if in fact you also send along something that indicates the patient's desire to have that information released, whether specific to that query or something more general, but that covers the information queried, does that then justify a requirement for a stepped up response on the part of the data holder. You know, again, I'm ...

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

Yeah, no, I hear where you're going and I'm only thinking about the fact that, the possibility that the provider that the patient gave this assent four years ago, you know, and it's in the files and therefore it's still ... I mean, I'm not saying I'm against it, I'm just trying to understand what I'm for.

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

Yup, yup. No, absolutely.

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

And this is David. I'm just testing even further boundaries to say, if we build systems that manage all this knowledge about patient's intent to share and not to share, are we breaking the law when it's a treatment relationship. I mean, if we stood in the way of a release of information to a treating, because of a captured patient consent, it sounds like to me that's not what's supposed to happen, according to ...

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

Nothing stands in the way, right; it's only a question of whether we're implying a virtual safe harbor.

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

Well, but I'm thinking, what I heard was, the revue- ... you can request a restriction, but that's not up to the patient to determine whether the data is actually restricted. So if we build systems that let the patient feel like they are in fact managing restrictions, are we in fact, going too far?

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

Oh, I thought we were way beyond that. I thought we'd taken that out of the conversation entirely and we were only talking about the scenario where there is a request, either always with an attestation and sometimes with some more specific consent.

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

But I was testing the boundaries to say, if there's an attestation that this is a direct treatment relationship-related request, is that where we actually have to stop, and that notions of giving the patient the power to restrict who you send that request to, is actually ... that's not a requirement ...

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

But, that's not something we're disc – well, I'll let Deven ...

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

Yeah, that's not on the table David. That's not on the table. And in fact ...

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

It's a logical consequence though of what you've written, so it isn't on the table but it's going to fall out in the design of the systems, so ...

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

Well ...

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

... I'm sorry to take us in the wrong direction.

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

Let's take this back to the basic, I think, question that we're trying to resolve, which is, what do we want to enc- ... we sort of started with this sort of moral equivalent of a safe harbor, right, that essentially was saying to data holding entities, look, you really should be releasing data in response to queries when they come with the right information attached to them, absent some other legal requirement that would have you hold it back, right. Again, thinking about where we really started back when we initially did consent, we said, look the physician is the gatekeeper and the keeper of trust in access to a patient's record. And when the provider still makes the decision about when to disclose information, including potentially in response to a query, then you don't necessarily need any additional consent. But when that decision-making capacity is not there anymore, such as through some centralized forms of HIE, then there should be meaningful choice about whether your data is sort of part of one of those arrangements.

When we turned back to that set of questions in thinking about response to query, there was an expression of concern that providers might take that gatekeeper role and occasionally use it to avoid sending data, even in circumstances where there is a treatment relationship, but because of, for anti-competitive concerns, they don't want to share the data. And is there a way to sort of require them or strongly encourage them to share in certain circumstances. And it was through that discussion that there was the sense that when you've got the patient asking for the data to be released, even in circumstances when it's not necessarily a legally required authorization, that that sort of ratchets up the response that the provider should give, which is, well, you know the patient's asking for this in addition to it being an attestation of a treatment relationship. But we can sort of unwind some of the assumptions for that discussion if we want to, but I think the basic question from a policy standpoint that we're trying to resolve is, in a query situation, what is the minimum response that ought to be from a data holder, and does that response vary depending on the circumstances. And what's the minimum amount of sort of documentation or attestation that has to come from the person making the query. I think – let's resolve that set of issues, then I think the rest of it, all of these different permutations, what about restrictions, etcetera, etcetera, we can successfully deal with.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Deven, this is Dixie. I thought that summary was excellent, right on the money. I think that one – in coming up with what is the minimum, in a ... many ins ... perhaps many cases, but certainly it's not uncommon, there may be multiple requests for information. I think we need to make it clear whether this attestation needs to be every single time you ask, or can the system record that, yes, this person has a treatment relationship so that the attestation doesn't have to be repeated.

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

One of the ways that I – I think that's a good question Dixie, and one of the ways that I tried to think that through was on the slide about allowing providers to sort of be able to set their EMRs to sort of automatically respond.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Oh, I didn't get it from that.

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

Yeah, that's okay, I mean ...

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

... that that was just – yeah, I got your message kind of response.

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

Right. Right.

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

This is David. I mean, the only point on that though is obviously treatment relationships can have varying durations, some can be one shot, fix the broken arm, and others could be lifelong, chronic disease management. So, I don't know how you can infer, you know, automatically what the duration of a treatment relationship is, without some way of stating it.

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

Well ...

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

Yeah, this is Wes. I agree and I feel we're designing the system that can't be built here. What we're trying to do is simplify and help to enable the process of sending information. I don't see why it's not – I don't see why there's any problem with saying, at the time of the request, it's incumbent on the requestor to specify that they have a current treatment relationship with the patient.

**F**

Yeah.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

And, or they, and they have the authorization to receive that information.

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

Well, now that's what we're discussing ...

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

Well, say what you mean John by authorization. Are you talking about that they're sort of legally allowed ...

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Yes.

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

... to ask for it, as opposed to the patient's authorization, right.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Well, I mean I guess, just because ...

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

So when do they not have – when are they treating the patient and they don't have the authorization to receive information?

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Well no, but I think it goes a little further than that though Wes. I think, actually maybe I'm stepping over the boundary to Wes' other point, but, there are things we can put in our consent for treatment forms that do specify that we're going to be making this request. Why – I mean I don't know why we can't include language in there that also at least provokes the conversation about whether this patient still agrees to have their information shared.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

And especially since we're not talking about these special categories of information. We're just talking about the generic case, right Deven.

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

Yeah, that's what we're trying to solve first.

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

I would say that in ... we should make it as simple as possible, absent the need to make it more complex. And in particular I'm proposing something that's moderately complex, which is that they get special, the request gets extra weight with the record holder if they say, we have a specific consent or authorization or assent or yeah for sure, whatever you want to call it, from the patient. As opposed to, the requirement that they say explicitly and affirmatively, if that's not redundant, that they have a current treatment relationship with the patient.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

I think that that's okay if it's not an emergency situation. If it's an emergency situation, I think all of us would want information sent if we were not able to give consent.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Well, hold on, that is – well, except that, if the patient has previously indicated that they do not want their information shared, then in that particular case, then one might argue that we shouldn't be sharing information, only whether it's silent or in the past they have assented to having their information shared, should we, I think, make that assumption.

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

But we just heard from OCR that that's not how it works.

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

I'm not sure that we did David. How are you interpreting OCR to say that it doesn't work the way that John said it works.

**David Holtzman, JD, CIPP/G – US Department of Health & Human Services, Office of Civil Rights**

I'm sorry, I am multitasking and I didn't hear all of what John had said.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

What I said was that, Judy's point was that in the case of an emergency, information should be shared. And I said, well not ... and my opinion is, if the patient either has stated that they do not want their information shared or they instead in the past agreed that their information be shared. I mean I think in the past where it has been shared, they have assented to it, then great, would share it even in an emergency circumstances. But if they had said that they do not want their information shared, then in my opinion they have indicated their preference and you, that's what we've done and our HIE has said, "Hey, you say that, we're not going to share it."

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

(Indiscernible). Go ahead.

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

Right, but keep in mind, I'm just going to interject here, keep in mind that this, that John's response was in response to Judy's remark about releasing data in emergency circumstances. Also, keep in mind, John, that that policy is the decision that you made as part of a Health Information Exchange and the policies that would govern your network.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Absolutely.

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

In that situation then, the HIPAA ground rules about sort of right to request a restriction and whether that has to be honored or not.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

No, you're absolutely correct and I – you are right; I was extending this I think to what we've experienced with all of our members and their comfort level.

**David Holtzman, JD, CIPP/G – US Department of Health & Human Services, Office of Civil Rights**

Could I step in for just one moment?

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

Yes, thanks David.

**David Holtzman, JD, CIPP/G – Office of Civil Rights**

Okay. So, we can put this to rest by first of all, if the provider has requested, accepted the request for restriction, there is a specific provision in the Rule which provides for the release of what would otherwise be restricted information to, for the purposes of emergency treatment. And, I would be happy, so that we can kind of take this little background on HIPAA offline, because it's been, it is widely known. I'd be happy to send each of you information about this request for restrictions and sort of a little fact sheet about it, because I know it's been a long time since a lot of people have had to think about it and, we don't want to step HIPAA requirements into the pivot of this argument. Thanks

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

This is Judy. I would like that, so thank you. I would like to also answer Deven's question which was, what is the minimum, what is it that should be sent, that you asked earlier, Deven.

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

Um hmm.

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

And if I could give my proposal, I think what should be sent is the CCD, CCD information, CCD records should be sent, with the exception if the patient has specifically said not to send.

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

Okay. So I think you're a little bit ahead of ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Wasn't that what you asked, what should we send?

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

Well, I was actually talking about, that comes with the query.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Oh.

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

I think you were already at response. But ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yeah, yeah, yeah, that's right.

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

But that's okay Judy, because we'll just put that on the table for now and we'll bring it back when we're ready to talk about the response. Because I thought that ...

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

So Deven ...

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

I mean, I thought that where we were sort of coalescing again, was that certainly at a minimum queries have to have an attestation of a treatment relationship, which presumes legal authority to ask for the information. Because you're attesting to that treatment relationship so darn it, you'd better be in a position as the treating provider to be able to legally be getting that information. Now, I think what Wes said is, in terms of sort of when we get to the piece of sort of what the response of the data holder would be, maybe there's value to extra weight, when that attestation also comes with some sort of documentation that provides, that demonstrates that the patient wanted that information to be released.

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

Deven, and that's in the context of our prior discussions that said, there is no legal obligation ...

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

... to release ...

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

... on the record holder to release the data, except directly to the patient.

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

That's right, that's correct.

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

But is this – this is David. But, these are being cast – we have to cast this as best practice, recommended best practice; it's not HIPAA minimum, it's beyond HIPAA minimum, right.

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

No, hold on. We are not suggesting that an authorization or consent, or assent or some sort of yes go ahead from the patient is required as part of a query.

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

Right, we're saying it's a best practice.

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

No, what we're saying ...

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

We're using words ...

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

No, what we're saying is, if you're a data holder and what's coming to you is not just indication that this information is being requested for treatment, which is what's needed to justify disclosure of it under HIPAA. But also, an indication from the patient that they would really like this information to be disclosed, and you take a look at whatever that consent is, and say, oh, yeah, it covers my situation, what does that mean for your response? Not a best practice to include it, not a requirement to include it, but to what extent does that create an additional professional obligation on the data holders end to provide that data and then that's where we get to the issue of, what then does get provided in response. Is it the CCD, especially in the case where the patient has asked for that data to be shared, or is it – you know, or when you're just relying on a treatment ... attestation of a treatment relationship and you have some hesitancy, what's the response there. I think that's the piece we're trying to get to. But I don't want to leave ...

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

We're still talking about the request, right.

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

Still talking about the request.

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

No, I, I mean, I thought – I kinda feel like we've moved on ...

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

I thought so, too, but ...

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

In other words, it's the whole thing about what does it mean to say that there is some – there is no legal obligation, there's some ethical obligation, somehow we're saying it's more if there is direct evidence that the patient really wants this. So, what is the ... it really is that ... um, we really seem to be talking about what are the recommendations of the Policy Committee perhaps for how a record holder should treat this request ...

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

Yup.

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

... and we could, of course, be talking about recommendations that could require or could be further buttressed by changes in law or regulations or something. But, it – I think we're having a lot of trouble around this issue about what does it mean you're obligated to send it, but you're more obligated.

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

And that's why I was using language like best practice, because we are defining a preferred way to do it or a morally equivalent way to do it or something, but it's not the law, per se, it's not the minimum of the law. I totally agree that we should do it; I'm just trying to understand ...

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

What is it?

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

... what are the requirements at the minimum around the necessity to capture something beyond attestation for treatment that is direct treatment? It sounds like we all want consent, but I'm not sure exactly what we do with that consent.

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

Well, right. I don't think – I think we are not requiring it. Let's stay on the responsibilities of the data holder, when they get a query ...

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

I think we need to also address ... how the, how much information should be included with the request, with respect to the identity of the patient, because there is a risk that they ... receive the information of the wrong patient. So, I think that including sufficient information to make sure that you get the right patient's information is really important.

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

I would agree but suggest we could defer that until after.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

(Indiscernible)

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

There's one thing that confuses me. Deven, you said something about, if the patient also asks, remember that earlier?

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

Um hmm.

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

I don't – I'm trying to, in my mind, visualize situations where the patient could ask. So I go into the healthcare organization, I want my information brought over, I sign something, or maybe that I have already earlier given authorization, but that isn't directly asking. I'm trying to envision, there I am, in the doctor's office, I bring out my cell phone, I call the University of Wisconsin Healthcare Center, speak to the person at the desk and say, I want my record over. I can't imagine ...

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

Judy, you started all this a year ago when you talked at the Policy Committee about your experience with a broken wrist, right, and the way ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yeah, but I didn't – I asked through the health care organization, I didn't specifically ...

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

You asked through the treating organization to have the data sent from the record-holding organization, right.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Right, I signed that consent. But I thought we were saying that is not the same thing as if I directly ask.

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

No.

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

No, I think that is the same thing as directly asking.

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

That is the same thing, Judy.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

That is the same thing?

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

I think we're trying to encompass a sort of range of ways that a patient could ask or have consented to, or have assented or have authorized the release of data.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

But I thought – I thought last week at the meeting you specifically said that if the patient asked, it can go over, but if the organization asks on behalf of the patient, it can't. And what you're adding to that then is unless the patient has signed something, in which case then the organization asking on behalf of the patient means the patient asks.

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

Well, if I gave you the impression that it had to come directly from the mouth of the patient versus being presented by the requesting organization in some way, then my apologies.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Oh yeah, that's what I thought. I was wondering ...

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

I think we're confusing the HIPAA legal requirement with the scenario we're trying to paint here.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Okay.

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

The HIPAA legal requirement is what you just said Judy; there isn't a legal requirement to release it except to the patient on the patient's direct request to the record holder. But we're talking now about a scenario where there's at least some goodwill and some sort of moral pressure on the record holder to release data when it can assure itself that it's not doing it illegally. And, we're talking about how much – what are two levels of assurance we can give it? One level is simply we assert under penalty of death or whatever, that ... or OCR investigation, that we do have a current treatment relationship with the patient. The second level of assurance we can give the record holder is the first plus we have a specific either electronically or manually signed document from the patient, signed at some time, saying they would like data to be transferred to this organization for them.

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

And (indiscernible) see where Epic ...

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

To carry that just a little bit further. I'd like it not be signed, but that the patient electronically can do it as well, set it up on his or her own portal to say specifically these places or, for me, I would say any place in the world where I'm being treated, I want that information over.

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

Well it's just – what is in the hands of the requesting HDO to, that it can offer over this transaction, in order to assurance. I'm trying to avoid ...

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

... micromanaging the ...

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

... creating some situation where the policy requires a third party be involved.

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

Right, and I also think we should try to avoid a circumstance where the policies dependent on a very specific model. Allowing for automated, allowing for some way to program in responses, some technical way to do this better, faster is fine. All I was saying was that, when you've got some indication that covers the query, that this is what the patient wanted ...

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

Yeah, that's why I ran a whole bunch of "ors" together in there, I was trying to be – to create the sense that we are not narrowly defining how this assent was communicated to the ...

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

Yeah.

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

... requesting organization, we're offering the widest possible variety as possible. We are saying that assent has been communicated, has been relayed from the requesting organization to the record holding organization.

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

Right. And the reason why it's significant is because we think that in circumstances where there's reasonably reliable indication that this is what the patient wanted, that the response of the data holder, there's sort of a best practice for them to respond. I think David's right, you can't legally require them to respond, we don't have any tools for doing that, but they really should.

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

At a minimum, it takes away one of their excuses for not responding.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Can I ...

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Are we totally ignoring the other excuse of, well, I need more information about which patient you're asking...

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

No, we're definitely not ...

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

No, we're going to get to that.

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

... I left a placeholder for that.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Okay.

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

Yeah.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So, this is Micky. I'm just wondering if the, Epic's experience could help inform this a little bit here. And Judy, please correct me if I'm wrong, but my understanding is that the RotR or the rules of the road for care everywhere have kind of this basic structure that we're talking about. And there is sort of a ... either explicit or implicit, I haven't seen the actual document, but, of the data holding entity, there's sort of a duty to respond with the information.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yes, and ...

**Micky Tripathi – Massachusetts eHealth Collaborative**

... and if they have – go ahead Judy – I'm wondering how often does that happen that they actually don't respond and then it enters this process where they ask the inquirer for further justification of the request before releasing information.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

You know, this is a really interesting thing you ask, Micky. Originally, when we started Care Everywhere, there were a lot of people saying, “I just want to communicate with this one and nobody else,” and it was primarily because those were their economic and medical ties, and they didn’t want to go anywhere else. And, it – people would come to me and say, “Judy, loosen up on your rule that it has to be everyone to everywhere,” because people were saying no. Well what happened then is that I didn’t loosen up and then people started using it and after a while, everybody said, this is the right thing to do, this really works and it’s right, and we have people everywhere coming in. We have found that there have been zero, I believe, problems with people not sending everything everywhere, with one exception, that is, we do have one group that I’m aware of, that refuses to sign on because they have another group, and it isn’t for economic reasons, that they don’t want to share with. And that’s the only exception I’m aware of, but everybody who is using the system, nationwide, shares with everybody.

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

Well, which, but you guys have a mechanism for enforcing that, right?

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

It’s the way the system works ...

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

Yeah.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

... I mean, the mechanism is that when a query comes over and it’s appropriate and we are checking that in fact, this is a patient at their site ...

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

Right.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

... and we’re checking on whatever authorizations need to be done, which may vary by organization and by state. So we have let them decide what the right things are, because we found that really does vary, both by state and organization, by relationships between different organ-, healthcare organizations as well. We follow the rules. If a patient’s signature is required at that moment, we get it; whatever the rules are, we follow, and then we ourselves on the other end are sending the data back. So, there’s no intervening. Now, if in fact the patient is not positively identified, then we go to, there has to be a phone call made and has to revert to the original manual ways of doing it, because we do not want to get into alerting anybody of any other patient. So unless we can identify the patient accurately, if we can we use the electronic processes, if we can’t, we revert to manual.

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

Question on the electronic processes.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Um hmm.

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

I’m just not sure I understood everything you said, but is it if the requestor – the issue that I’m trying to understand is the record holder is under different obligations for what they need to release information, according to where they are and other factors. Are you saying that there is a way that the record holder can electronically know that it has fulfilled those requirements and then they’ll be an automatic response or are you saying ... that’s the part that I’m having the difficulty understanding.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

I am saying that, yes.

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

Yeah, okay.

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

It's automatic, it comes over an automatically ... the CCD document goes back and when its Epic to non-Epic, it's a CCD document, when it's Epic to Epic, as with any vendor, we know more about what the data looks like on both sides, we can send more.

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

I'm interest – this is Kitt. Judy, I just had a question. What if the patient opts out like, or what about sensitive data?

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Sensitive data, it depends on what you define as sensitive data. We don't send, for example, the psychiatrist's notes; we don't send things that are specifically marked as sensitive. However, we do send the meds, we do send the lab test results and we ... interestingly enough, we direct our customers to tell the patients that all data will be sent. And the reason goes back to what we spoke about many times in the Policy Committee meetings, which is, you don't want any patient surprised. So, if the patient signs for all data going over, even though we suppress the details of the psychiatrist's meeting, we don't know how much will be put into the notes of the general practitioner for example, about for example, the patient's depression. That may be otherwise ... the patient might be surprised that that got over.

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

Yeah. I just want to interrupt for a second. We've de- ... we are trying not to discuss sensitive data yet, Kitt ...

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

I know, I apologize ...

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

... trying to keep with this use case we're dealing with, but the opt-out question is a relevant one. This came up at the hearing, did it not? Did I – I thought that I heard that customers can ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yes ...

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

... execute opt outs for their patients.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

... customers can allow patients to opt out.

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

... context of ... is this a request ... a response model that we're ...

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

David, we're really having trouble hearing you on whatever it is that you're using, I'm sorry.

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

Yeah, I'm sorry ...

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

You're under water ...

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

... it wasn't bad yesterday. I'm just saying, opt out at the responding institution is not what we're talking about now, we're trying to transfer that request – the power of the release to the requesting institution with the patient's active consent as opposed to a passive prior opt out.

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

Well, not exactly ...

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

(Indiscernible)

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

... I mean again, I think we're just creating a set of circumstance that ratchets up the sort of professional responsibility to respond. I think we're focusing more on the response of the data holder, putting off to the side, Dixie's questions about how much information about the patient for matching purposes is part of ...

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

So, I understand, but let's just take the scenario where at the responding institution the patient has opted out. Now, a year later or six months later, they are at a new treating facility and they consent to the release of their data, attach that consent to the declaration that it's a treatment relationship and send it to the institution where they have previously opted out. What are we suggesting would be the proper response of the responding institution? Should they honor – you see what I'm saying ...

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

Yeah, I do David, but that also feels like a next level problem, where there's competing – there's arguably competing instructions in both locations, as opposed to trying to solve for the simple case about what happens when you don't have competing requests, when you don't have a legal obligation to withhold, when you don't have something on record that says don't disclose and you get a query.

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

It's the happy pathway ...

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

Okay. I understand, I'm sorry for jumping ahead. It seems to me that there's no question that if there's no restriction and the patient says please release the data that you're going to release the data. I was just worried about the next level up where there are confusions about it. Because ... I want to ... what I'd like to see us do is to shift away from the notion that you do this opt in, opt out thinking at the record holder and you transfer it to the question of, do I want this data released or not to the record, to the person who currently needs it, where the patient currently is. As a broad rubric, that makes a lot of sense and simplifies the world a lot. But, maybe I'm jumping ahead, and I apologize for the bad sound, it worked yesterday, same ...

**Micky Tripathi – Massachusetts eHealth Collaborative**

This is Micky. I just wanted.. – David, I just wanted to get on one, I want to get back to, I think Deven's trying to boil this down just to the bare bones for the HIPAA base case and then start building up. And you said something ... you had a phrase that you said, there's no question that they would respond. I guess – it seems like that's what we're trying to address here.

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

Yeah.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Is there really no question? The reason I raised the Epic example is – and it's obviously comp-, a little bit more complex and there's more infrastructure both from a policy and trust perspective, as well as a technical perspective. But it seems to me that there is sort of – if maybe some information from Epic offline would be informative here, but, in that model, they make, one organization makes a request of another organization. Now it sounds from what, like from what Judy said that they have a little bit more of a technical capability to verify that attestation, to the extent that they can actually verify that there is a treatment relationship because they have the data from the patient. But, be that as it may, we could separate that out and say, well let's assume that you trust the attestation from the sending organization.

I guess the question that I have is how often is there no overhead on the sending, on the data holder side to the response. Now, there may be some legitimate things where, all right, I've got a state law that covers this or I've decided to have a robust ability to honor a patient's right to restriction under HIPAA, which is sort of a separate thing and the technology allows that. But I guess I'm wondering how often is it the case that there really is nothing on the data holder's side that they put in the middle that responds to requests, that they get it and they just respond and there's nothing left. Because that might be informative for us to realize, oh, you know what, 90 percent of the time, that actually just happens with nothing required, because that's what we would need to have happen if we're going to automate this across jurisdictions.

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

Yeah, no, I – this is David. I agree and I apologize for being too dogmatic. What I meant was, under the assumption that there are no barriers to the release, such as a consent or a state law that trumps HIPAA, and under the assumption that it is a treatment attestation that we trust. And under the assumption that we've been discussing, that the patient's consent accompanies the request, then in that case, I can't see a reason why we wouldn't suggest an immediate response.

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

Yeah. Yeah, I'd like to hear Judy's answer to Micky's question.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Micky, I didn't get your question. Could you – I know it went on for a bit, so I'm sorry to ask you to repeat it ...

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

How often do they really make an immediate automatic response?

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

All the time.

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

Yeah, exactly, all the time.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

That was the question. Okay.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, I guess the other ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

And having been the recipient of that when I've gone to places, it's instantaneous, boom, it's there. You sign ...

**M**

All right, you don't need to brag Judy.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

No, but it's – I don't mean it is a bragging, I mean, as a person who's going to the ED, it's – we're doing a good thing here to make this stuff happen.

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

So what I think I got from this, first of all, we have to be careful because in Epic Everywhere, Epic is operating as an HIE ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yeah.

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

... we have to sort of take that out of the equation...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

We don't believe so.

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

Well, all right. But you're operating as a – let's not, let's just be, let's just recognize there's a second, there's another agent besides the sender and the receiver in that transaction – ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Just the software – we're the software; we're not the agent in the middle.

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

Well right, but I think we have to presume that there will be some queries between entities that don't share the same software.

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

Yeah, all right. But ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Sure.

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

... at any rate, one lesson I took from what Judy described was that our, and this may not be a policy issue, now that I think about it, it may be a Standards Committee issue; but, the model for communicating the right assent from the requesting institution to the record holding institution is not as simple as a general consent form. There are, in fact, the model that Judy described, there's a specific way for the requesting institution to know in advance what it needs to supply to the record holding institution in order to for it to be able to automatically release the data. Judy, did I – am I interpreting what you said properly?

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Well, what we do is we allow the source organization, the record holding organization, to have its authorization communicated to the requestor, and that's the process that the requestor has to follow...

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

Could you repeat that?

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

... which allows us to go across state, across whatever.

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

Could you repeat that?

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Okay, so, the source organi-, the requesting organization uses the source organization's authorization requirements and form to sign or anything – whatever the rules are, it is the source's organization that the requestor has to use.

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

So there's a two-step process, one is send me your authorization ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Yes.

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

... and then the next is, here is your filled out authorization.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Right ... in fact ...

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

I think ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

... that way, that way it's much safer because you don't know the state rules, the organiza- ... anyway, go ahead.

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

This is David. And, I mean, that's a terrific clarification, but I was hoping we could evolve our, whatever we're going to call this, recommendation towards, to say you don't need that two-step process. If you can declare that it's a treating relationship and you have the patient's consent in the original request, you don't need a two-way dialogue, the first to get forms to go back and forth and the second to get data to flow.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Or you might exchange a pointer to it, too. It's like Deven said earlier, I don't think that we should make sure that our response has the whole how it's done, we should really focus on what needs to be done.

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

But it think in describing a policy, we are describing, we are recognizing that this assent is more than a simple form, it is, in fact, case specific, that ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

And let me expand on what David just said. I agree with you David, we do it both ways. So if the source organization doesn't require a form to be signed, then it's automatic and it just goes over.

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

Oh, that's great, thank you.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

So, it depends on what the requirements of the source organization are.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

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

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

That's helpful Judy.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

And Judy, do a lot of source organizations have a requirement for forms?

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

Right, that's my question, too.

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

About a third, about a third do; so about two-thirds don't.

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

And then what would be really fascinating to know is, of the one third that do, how many of them really need to, from a point of view of ...

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

Yeah.

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

... actual law and how often is that just kind of conservative operating principles.

**Judy Faulkner – EPIC Systems – Founder and Chief Executive Officer**

Right. And I can tell you that they hate the paper accumulation.

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

Yeah, I would think so. I would think so.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Yeah, and that's why I think that our response needs to not restrict it to the exchange of some form that's signed.

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

Right.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

I have a question about, and maybe this is to David Holtzman. The – if a requestor sends a point to whatever, but they send a consent to the data holder somehow, the data holder then has that consent, but my understanding is that they would interpret that consent within the constraints of the data holder's state law, right?

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

Oh, absolutely Dixie.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

So it's ...

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

Because it ...

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

... consent from California, it would then be interpreted within the context of West Virginia's state law.

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

Well right. I mean, if the data holder lives in...is residing in West Virginia and is subject to West Virginia law, then any disclosure they make from their records has to be consistent with whatever their legal requirements are, which is ... as a baseline plus state.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

That's what I thought.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

And you want to make it so that it could vary, so that if the data holder is in West Virginia, it can perhaps have different rules for other organizations within West Virginia than it does outside of West Virginia.

**Dixie Baker, MS, PhD – Martin, Blanck and Associates – Senior Partner**

Yeah, yeah, yeah.

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

But aren't we trying to get a simple case rubric that would – I guess the question maybe is, can our simplest case, can an attestation for treatment plus request, can we make that trump, how many state laws would...

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

No.

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

... be in the way of making that automatic.

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

No, no, no, we cannot trump state law. And David, all we're trying to say, because we're not trying to override existing legal requirements, and we can't create a requirement to disclose that information because we don't have any policy tools to enforce it. What we're trying to say from a policy matter, and maybe it really is more of a best practice, is that when what you're getting is a query that has all the right attestations and you're getting some reliable indication that the patient actually wanted this, you really should respond. I mean, maybe you really should respond to just the treatment attestation absent a valid reason for not, but certainly when you've got the patient accompanying it, you should respond, subject of course, as always, to legal constraints.

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

Yeah Deven, thank you. I realize that we aren't writing any law here and that's why I kept coming back to the best practice notion. Is there some way we ...

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

Hold on, let David finish.

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

Is there some way we could find out that – your statement of, you really ought to respond under the circumstances where you meet the criteria of, you really ought to respond, how many states would not permit that to happen or ... I mean, literally make it illegal.

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

I don't – there are at least two states that I am aware of that require consent to release patient information ...

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Are those New York and Minnesota?

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

... in all circumstances, right. And then, of course, what the sort of parameters of the consent are varied. So when – so depending on what kind of assent is being presented with the query, they may not actually be able to respond because it doesn't quite meet their legal requirements. I'm not aware of any state that bars the sharing of data across state lines for treatment purposes.

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

No actually, this is Kitt. I don't think it's any trumping, the consent authorization, isn't that considered in the realm of the HIPAA and state regs and local policy and other patient authorization. I mean, I know that aligns with what Social Security is doing today, and there isn't an issue of it crossing lines, from what we've read and what we researched.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Can you say that again?

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

Sorry. Basically, the consent authorization is really considered in the overall realm of the HIPAA, state regs and local policy that there is today, and it aligns with what Social Security is doing today.

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

What do you mean by the consent authorization? Are you talking about the form that the Social Security Administration uses to get data?

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

Yes, and also under HIPAA, they have the paper that the patient fills out as well.

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

Except HIPAA doesn't require consent for treatment Kitt.

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

No, not for treatment purposes. I'm talking about in other areas, like Social Security.

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

Right, for specific ...

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

No, this is not, we're not there yet.

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

... for a specific authorization to release data in circumstances where the authorization is required.

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

Deven, this is Wes. I wonder if I can make a suggestion. I think we're just about out of time here.

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

Yup.

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

Can I suggest that the figurative "we" here, somehow work on a statement of the happy path that is just a little more detailed than the bullets you used in the slide, but that we look at the next meeting for the members of the committee to agree that that describes our understanding of the happy path.

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

Yeah, no, I would love it, I mean, that's essentially what we've been trying to do, but clearly we're not really getting there yet.

**Leslie Francis – University of Utah School of Law – National Committee on Vital and Health Statistics**

Deven, this is Leslie. One of the reasons I think we haven't been is we've been going back and forth between the situation in which there's some indication that the patient wants it and the situation in which we don't know, especially in the emergency set up.

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

I would argue that the happy path is the one where there is some indication, that every other path represents some additional complicating factor ...

**Leslie Francis – University of Utah School of Law – National Committee on Vital and Health Statistics**

Right, I would ...

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

... which we need to

**Leslie Francis – University of Utah School of Law – National Committee on Vital and Health Statistics**

... I think we were shifting to the complicating factors a lot of this time.

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

Yeah, I think it's normal, but ... that's exactly the reason why I'm suggesting that if we can agree, as a group, and of course it's a different group every call, but if we can agree, if we can agree on for this basic set of givens, this is what we believe, and then begin to elaborate on that, we could probably move the ball forward at least as well as San Francisco did.

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

Ouch.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

Whoa.

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

I'm from the San Francisco area ...

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

So you're allowed to say that. I could not have said that, so ...

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

That's Wes Harbaugh on the phone.

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

Deven, you would have heard a grown man cry.

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

Aww, I think I did actually, there were several, but they were drowned out by the screams of joy on the East Coast. I would love to have some help in getting this articulated in a way to sort of get some sort of the happy path defined in a way that then allows us to sort of get to these other either higher level issues, I characterize some of them, or some basic issues that we just haven't been able to get to yet, like the one that Dixie raised about how much information should be in the query.

**M**

(Indiscernible)

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

That would just be terrific. We've got another call coming up towards the end of the month, it's on the 21<sup>st</sup> of February, so we have a little bit of time ...

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

That's the day before the Standards Committee meeting, right.

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

Oh, I guess so; I actually don't have the Standards Committee meeting ...

**MacKenzie Robertson – Office of the National Coordinator**

The Standards Committee meeting is on ...

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

... so I won't be on that call, but ...

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

Oh dear, okay.

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

... but nonetheless, I think that's not an obstacle.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

Hey Deven, maybe a way to keep everybody on point here is, if we put toget-, if you could put together or somebody put together a simple flow chart of ... because it does get more complex as we get into different types of information and dealing with state law ...

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

Yeah.

**John Houston, JD – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics**

... is to say here's the box we're at right now, which is, the very simple. And then we can start to move down the path in the flow chart as we start to get into these more involved considerations, as to how we have to – how you have to deal with special cases or other things. And it might help us keep on point if we had a flow chart that says, where are we, what are we really talking to at any given time.

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

Right.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

That's a great suggestion.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Deven, this is Micky, I'm happy to help with the happy path if you need some help.

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

Oh thank you.

**Judy Faulkner – Founder and Chief Executive Officer – EPIC Systems**

And this is – if you send stuff around, I'm always happy to comment.

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

Yeah. No, you know what, we had a little bit of a compressed timeframe, well, they're always compressed, but more than usual for this one. I think sort of jumping on this and starting to articulate this both from a textual matter as well as through flow charts, I think that's a good idea. I think it would be really helpful as I feel like we're circling around some happy path recommendations, but I just – we're just not there yet and I'd really like to get there.

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

Micky, I'd like to wor- ... if you're going to take the lead for that, I'd like to work with you on it.

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

And this is David. I'd love to edit as well or ...

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

We're not going to – we won't leave anybody out; it's sort of maybe a matter of how closely people are paying attention to their emails. All right, anything else before we open up the phone for public comment. Thank you all for your patience, I think we'll get this, I know we will. But it has been a struggle and I appreciate everybody hanging in. All right MacKenzie, if you can open up the lines for public comment.

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator**

Sure. Operator, could you please open the line for public comment?

**Rebecca Armendariz – Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press \*1. Or if you are listening via your telephone, you may press \*1 at this time to be entered into the queue. We have no comment at this time.

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

All right, great. Thanks again everybody and we'll be getting right back to you real soon. Thanks for all the offers to help.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks everybody.