

**HIT Policy Committee
Privacy & Security Tiger Team
Transcript
April 16, 2014**

Presentation

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Privacy and Security Tiger Team. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Deven McGraw?

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

Here.

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

Hi, Deven. Micky Tripathi? Andrea Wilson? David Kotz? David McCallie?

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

Here.

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

Hi, David. Dixie Baker?

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

I'm here.

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

Hi, Dixie. Gayle Harrell?

Gayle Harrell, MA – Florida State Representative – Florida State Legislature

Here.

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

Hi, Gayle. John Houston? Judy Faulkner?

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

You called John Houston, I'm sorry, I was on mute.

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

Hi, John.

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

Thank you.

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

Kitt Winter? Larry Garber?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Here.

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

Hi, Larry. Leslie Francis?

Leslie Francis, JD, PhD – University of Utah College of Law – National Committee on Vital and Health Statistics

Here.

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

Hi, Leslie. Stephania Griffin?

Stephania Griffin, RHIA, CIPP, CIPP/G – Director, Information Access & Privacy Office – Veterans Health Administration

Here.

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

Is that Stephania, how do you say it?

Stephania Griffin, RHIA, CIPP, CIPP/G – Director, Information Access & Privacy Office – Veterans Health Administration

It's Stephania, but everyone calls me Stephanie.

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

Okay, Stephanie, that's easier. Wes Rishel?

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

And is Kathryn Marchesini on from ONC?

Kathryn Marchesini, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Here.

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

And are there any other members from OCR on the line?

Verne Rinker – Health Information Privacy Specialist – Office for Civil Rights

Verne Rinker.

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

Hi, Verne. And with that, I'll turn it back to you Deven.

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

Okay, great. I just want to double check, I think we were going to be joined by one or two folks from the Substance Abuse and Mental Health Administration are they on?

Kate Tipping, JD – Public Health Advisor – Substance Abuse and Mental Health Services Administration

Hi, this is Kate Tipping from SAMHSA.

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

Okay, great. Just wanted to acknowledge your presence on the phone, that's great.

Kate Tipping, JD – Public Health Advisor – Substance Abuse and Mental Health Services Administration

And I think Maureen Boyle will be joining us.

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

Oh, terrific, terrific. So, we really have you guys on deck, in case any questions come up for – about the Part 2 rules that I think are going to be talked about by a number of our presenters today.

Kate Tipping, JD – Public Health Advisor – Substance Abuse and Mental Health Services Administration

Okay.

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

So, thank you very much, we very much appreciate it. So what we have today is a really very packed agenda. We're going to be continuing our discussion of the Data Segmentation for Privacy pilot initiative and it's sort of readiness for greater use. The questions were teed up for us by the Certification/Adoption Workgroup that's considering some certification measures for – voluntary certification for behavioral health records and they're initially poised to make a recommendation about having the same technologies be present in other provider EHRs.

But they have teed up for us a review of that initiative and based on some discussion that we had on our previous call, there was a very strong interest by members of the Tiger Team in hearing more about both the pilots. As well as what providers are doing today, with respect to sensitive data that may be subject to additional consent requirements, including behavioral health data. And what we have teed up today is essentially four folks to talk to us both about their current experiences with collecting and sharing this type of sensitive data, as well as some more information about the pilots and hearing from one particular health information exchange initiative with respect to how they handle behavioral health data.

We have again are – we don't have much time to begin discussing as a Tiger Team. What we hope to do today is to have 20 minutes for each presenter. They'll give a presentation of five minutes and then followed by 10 minutes of time for questions and so this is really more of an information gathering call and we'll be able to have discussion on our following call, which is a week from Monday, on April 28. So, try to, in the interest of keeping to the schedule, try very hard, and let's try very in our questions to keep them as tight as possible, but also keep in mind that opining on sort of the rightness or the wrongness of something is probably best left for the discussion period rather than eating up the question time.

I'll also say with respect to our presenters who we have on the phone that we really will keep you to the time. It's not easy to be hard on you because you're doing us a huge favor by talking to us about these issues, but what we have found in the past is that the question period is where we probably get the most amount of information that's in fact useful for the Tiger Team. And so the more directed you can be in your presentation to the discussion questions that we circulated, as well as in your responses to

questions, you'll be helping us out all the more. Your willingness to even be present, though, we give our sincere thanks for that.

So Micky was not sure he would be able to join us today, so I think I'll pause for a moment to see if folks have questions. And if not, we'll jump into our first presenter, who is not only going to give his 5 minutes of presentation, he's also going to take us through the landscape of the laws that he has to deal with in Massachusetts, which is one of the states that tends to have more requirements on consent than some of the others. And so given – and he's also a Tiger Team member. We have asked him to give that presentation prior to the beginning of his five minutes. But before we turn to Larry, I want to see if anybody – any other members of the Tiger Team have any questions.

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

Deven, this is David. You led off the call by describing the context as a request for the voluntary certification. Is that the only context that we're thinking of this in?

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

No, no, no, no. What the Certification/Adoption Workgroup has sort of initially teed up to the Policy Committee is both voluntary certification for behavioral health providers, but also a requirement that EHRs generally be certified to the same privacy requirements. Because the expectation is that this data is not just going to be shared among behavioral health providers, that it's also going to come to general care providers, too.

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

Well, that was my impression and I just was confused, I thought maybe the scope had changed, but thank you for clarifying.

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

Yup, appreciate it. Anything else before we jump in? Somehow, I'm already two minutes behind, demerit for me. All right, well Larry, are you ready, we'll give you –

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

You bet.

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

– your three minutes on the law and there are no slides for this – for his presentation, right Larry, or do you have slides?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

That's correct, no slides.

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

Okay, so nobody has to worry about not being on the Internet. So go ahead, Larry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Great, thank you. So I'm a practicing internist in Central Massachusetts. I'm part of a large, multispecialty group practice and we have several psychologists as part of our practice, but no psychiatrists, and we all share an electronic medical record. We've been paperless for six years. But I wanted to start out, as we talked about, giving a little bit of a view of what it's like from the regulatory perspective here in Massachusetts.

We recognize that there are actually 16 separate privacy and security laws and regulations that pertain to us in terms of behavioral health or other privileged information. These are the federal laws and regulations such as the CFR – 42 CFR Part 2, also the HIPAA privacy and security regulations. We also have Massachusetts law, rules, and regulations and then there's also legal precedent that we follow. And so what we did is we identified that there are actually 11 categories of privileged information that can only be released by us with a patient-specific informed consent or a court order.

So for instance, there are the consultation notes of social workers, psychotherapists, marriage – licensed marriage and family therapists, domestic violence counselors, sexual assault counselors. And then there are also the records related to a patient's participation in an alcohol or a drug abuse treatment program that's both under the federal rules as well as Massachusetts Department of Health. And then there are also regulations regarding the release of blood alcohol testing, only if it's ordered by the police, so if I order it, that's not an issue. Also, records pertaining to sexually transmitted diseases, HIV and AIDS. Genetic testing in Massachusetts is also privileged, which oddly enough includes, for instance if you were to have your blood typed, whether you're A, B or O, that's privileged information.

We also have privileged information regarding illegitimate births, abnormal sexual births and fetal deaths. So – and then lastly under HIPAA, we're required to redact family member names, even though in our family history we often will collect a member – the spouse's names and things like that, those can't be released per HIPAA. So that's sort of the environment. And now what I'll do is I'll get into my 5 minute talk, so I saved a minute there, I think – five-minute talk on what's – some of the issues that you've been raising.

So first of all, we feel that because of all these rules and regulations, patients and regulators feel that they have a good handle on the privacy of this information and the reality is we believe that that's actually a false sense of security. Because it's not like these are discrete, outside records that are being accessed by us or sent to us, it's actually our records as well; it's my records as well. I'm a physician and that all of us physicians, specifically in primary care, do counseling, we document social issues, marital problems, domestic violence, yet technically, by the law, this isn't privileged information because I'm not a licensed counselor.

And there's also the fact that most of us physicians will also be prescribing controlled substances for our patients that are involved in alcohol, drug and treatment and because of our DEA licenses, we could be considered also falling under Part 2. And in Massachusetts, we've got – even though fetal death is protected, it turns out that abortion is separate from fetal death and is not protected. So I could be writing about abortion in my notes and it's not considered privileged information. And so this privileged information and then the non-privileged sensitive information is permeating all throughout our electronic medical records, you'll find them obviously standing out in a problem list, but they'll also be buried inside my free-text notes, they'll be in my med lists or implied by allergies or implied by test results.

And to make things more complicated, we have numerous sources of information in our electronic health record. So there's obviously the information that I enter or my colleagues enter, so that includes the psychologists. Now the psychologists have their therapy notes, we have them sequestered within the electronic health record in such a way that actually, only the psychologist can see them, I can't see their notes. But what they'll do after seeing a patient of mine, they will put a treatment summary in the electronic medical record that is visible to all of us, so that summarizes what they're treatment – what their diagnoses are, what their treatment plan is. And then at the end of their treatment, how the patients did.

But we also have data coming in electronically from hospitals, as well as automatically from claims data from our payers. Because we're a financial risk, risk sharing for most of our contracts with payers, we get claims data that includes behavioral health diagnoses and procedures, which automatically populate my electronic health record, filling in the past medical history section and the encounter history section.

And then we also get paper records. So for instance, outside psychiatrists or we have a couple of drug alcohol treatment programs in our area in Central Massachusetts, those come in to us on paper and the way we deal with that is that they're first sent to the physicians and we personally abstract them into our electronic health record. So I'll take out the diagnoses and I'll put them into my problem list or I'll put them into my notes or I'll add the methadone or other treatments into the medication list. And so that it begins inter-digitated right in our record with everything else that's in there, seamlessly, and then we scan the full document as well.

So it's imp – because we have information coming from so many different sources, integrated like this in a seamless way that's very easy for clinicians to view it and access it. It also makes it that much harder for anybody, whether it's a computer or a human, to correctly segregate the information as it's being released. So it's almost impossible to guarantee that when a patient does not authorize release of certain privileged information that that information won't get accidentally released.

Now, I'm also concerned – we have concerns as we thought about our policies for record release, we thought about the harms due to the fact that we're sending potentially records that are coming from us, who people are theoretically trusting, yet we know that they will have Swiss cheese. A patient will have – I call these Swiss cheese medical records where there will be record – pieces of the record missing or redacted because that's what the patient did not authorize. And so we're concerned about the medical risks and our own liability from unforeseen drug interactions, preventable allergic reactions or misinterpretation of symptoms that the person receiving our records may have to deal with if they're receiving these Swiss cheese records.

We pride ourselves in our organization of providing high quality, safe care and our alerts, for instance, that are – that trigger inside our electronic medical record take advantage or all the information, behavioral health whether it's generated internally or externally, all that information is taken into account when we get drug interaction alerts or other sorts of alerts.

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

So Larry, you have about 20 seconds. Sorry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

All right, so how do we – I'm getting there actually. So the question is do we find the information from behavioral health important? Absolutely. It's absolutely important information to me; it helps me improve the care. So the policy that we have for releasing records is that for manual release of paper records, patients specifically have to opt-in for the – information for alcohol or drug abuse, genetic testing, HIV, STDs, mental health. And then we have pa...our medical records staff manually redact, to the best of their ability, this information to match the patient's request. And then lastly for electronic release, patients are entirely either in or out, so either they opt-in for all of the privileged information categories or we do not release any electroni – any information electronically. And I'm done.

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

Okay great. Thank you Larry much appreciated. I want to open up the floor for Tiger Team member questions for Dr. Larry Garber.

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

Deven, this is David, I'd like the lead, if you – that's okay.

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

Sure – you're on.

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

Larry, could you elaborate on the last statement you made, the distinction between redacted release and the all or none release. You went so quickly I think I may have missed something there, so I'm going to give you another minute by asking this question.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Nah, nah, nah, nah. Okay –

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

That's allowed, that's allowed, that's absolutely allowed.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you. So we divide them up into the manual release of records which are – there's a specific paper consent form for the paper release of information, and that's managed by our medical records department. And patients specifically can – have to opt-in for those specific privileged categories. And if they don't opt-in to release HIV information or alcohol and drug abuse treatment information, our medical records staff goes through the record and manually do their best to redact this. And sometimes it's an encounter that's – typically; it's at the encounter level that information is not released. They will sometimes cut out pieces, not release the medication list, parts of lab test results.

That's in opposition to our electronic release. In other words, through interfaces, through the Mass HIway, which is our state's health information exchange, in order for patients to – in order for patients to allow electronic release, they have to be completely in and agree to all categories, because we do not feel that we can even come close to attempting to segregate our data electronically.

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

Can you – this is David again, do you have some rough estimate of what – of how patients typically make that decision? Is it mostly they opt-in or mostly out or 50:50, or –

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

The vast majority of patients opt-in. And I think that's the experience we've seen with health information exchanges such as the Mass eHealth Collaborative in Western Massachusetts. When a community was well-educated, both the patients and physicians and staff were well educated about the benefits and risks of health information exchange, about 95% of patients opt-in to have all of their information shared, and only about 5% of patients opt-out. And that's one of my concerns is that I think because the vast majority of patients, I mean if 5% of patients get their peace of mind knowing that they have absolute control of their record, they know exactly who sees what, and that's great. But 95% of the patients get their peace of mind knowing that when they show up knowing that when they show up in the emergency room, their records are there, without a hassle, to help save their lives. And I think that we need to have a system that works great for that 95% and then another mechanism to achieve the needs of the 5%. And my concern is that a lot of policy is pretty much on the 5%.

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

Right. So Larry, I'm going to – I'm just going to ask for people, especially since you're a Tiger Team member, you're entitled to your opinion, but you have multiple opportunities to give it, as a Tiger Team member.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Okay.

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

And so sticking to sort of the facts of what you do today and don't would be, for purposes of this call, would be helpful. Appreciate it.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Okay.

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

This is Leslie Francis; can I ask a quick question?

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

Sure, go ahead Leslie.

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

Larry, do you have any different experience with release of records outside the healthcare context, for example, to employers.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

To employers, we do have an occ health department and we actually require patients who are seen in our occ health department to – in the opposite direction, we require the patients to give consent to release the information to our – the primary care physicians. But we don't really – I'm not aware of the release in the opposite direction, other than in the context of occ health. In other words, those occ health specific visits are the only things that occ health – that providers business –

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

So – I mean I was concerned about things like patient's who might need medical documentation for Family Medical Leave Act purposes.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So, we do a lot of FMLA and those are – we have – we receive them with a patient's signed consent perhaps to have those completed and we'll put in pretty much any information that's necessary for that form.

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

It's paper-based though.

Wes Rishel – Independent Consultant

Wes Rishel?

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

Hi, Wes, go ahead.

Wes Rishel – Independent Consultant

Yeah, I checked in late, by the way. Larry, two really quick questions, I'll give them both. One, in the manual release, is it apparent to the receiving physician that information has been redacted or is it just simply no idea of that? And then, in your statistics for who opts in and who opts out, do you have any statistics on the people who have the specific problem, such as HIV or alcoholism and how they tended to choose between opting in and opting out?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Both great questions, I do not have the statistics on the latter, but I'm tempted to try to see if I can dig that up, somehow, certainly not today. And in terms of the manually released records, my understanding is that you can't actually tell in most cases if something's been redacted.

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

You can or cannot?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Cannot, the recipient cannot tell.

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

Good question. I know I have a question, but I'm willing to defer to other members of the Tiger Team if they have one. All right, I'll go ahead. So Larry, if you get information that comes in from a behavioral health provider, through a referral to your system, but the behavioral healthcare provider is outside the system. So it comes in and presumably has the consent of the sending provider, what do you then do? Do you – let's say the patient doesn't come in immediately or then schedules a visit, do you contact the patient ahead of time or do you talk to them at the point of care when you take care of them to say, for any subsequent disclosures of this, I'm going to need your consent in order to care for you. How do you generally handle it?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Actually, it's funny you – we actually – we don't get referrals coming in that direction. In other words, we always refer out to behavioral health providers, like a psychiatrist to help in medication management on the patient or I'll refer out to an alcohol/drug abuse treatment program. But I actually don't – we don't get referrals coming in the other direction, that's what you were asking, is that correct?

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

Yeah, no, that's absolutely correct, because I think that's one of the questions that we are going to be asking folks today.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Yeah, we do get – when I do send someone to a behavioral health, they are interested in the patient's records and we do send them as part of that referral, information that I have on the patient.

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

This is Dixie, Larry. Following up on that response, because I'm kind of surprised. I had been told that behavioral health had their own systems and it's always obvious that behavioral health records – almost by definition behavioral health records are those that are generated by behavioral health systems. So when you speak of, throughout your talk, when you speak of behavioral health information, would you define that? What are you – exactly are you talking about if you're not talking about data from a behavioral health provider or system?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So there are – basically there are a lot of different things that are – that we consider equivalent to what should have been privileged information. So for instance, the therapist notes for marriage and family counseling, is – if I was a licensed marriage or family therapist, that would be protected, privileged information that couldn't be released. Yet in reality, my notes have that information because I'm doing marriage and family counseling in my office. I'm counseling on domestic violence and sexual assault and I'm helping manage alcohol and drug abuse treatment in my practice, even in addition to anything that might be coming in from the outside. And then there are the gray zones, which are, my psychologists who are doing psychotherapy. Their actual notes are absolutely sequestered, but the diagnoses and the treatment plans which sort of summarize what they're doing are in my records and visible and releasable.

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

Well are those types of data within the Part 2 definition of behavioral health records?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Well potentially, I mean, that's the thing. That potentially – the fact if that if I prescribe a benzodiazepine for – to help with someone's alcohol withdrawal, which I have done and do periodically, as do my colleagues. In theory, that would fall under Part 2, at least to our interpretation, because I'm doing it under a DEA license, that I'm prescribing that, which is a federal license and one branch of the government, because it's very – Part 2 is pretty broad.

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

Whoa.

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

Yeah, yeah, I think with that kind of a definition we have an intractable issue.

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

Well, one of the things – this is Deven, one of the things we'll do when we have more time to talk to the representatives from SAMHSA is to get some clarification around interpretation of that law.

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

Good, good.

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

I'll say it didn't sound quite right to me, but then again, I'm not the expert and they are, so we'll follow up with them. Keeping an eye on my agenda here, Larry, I'm glad you're a member of the Tiger Team so we can continue to have your voice in subsequent calls, but we do, in our forced march today, need to move on to our next presenter. Do we have Matthew Arnheiter?

Matthew Arnheiter – Vice President – Netsmart Technologies

We do, I am present.

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

Oh, terrific Matthew, thank you very much. So, were you here in the beginning, you know the drill. We need to sort of – we need to keep you to 5 minutes for the guts of your presentation, but you'll have opportunities to make additional points during the Q&A. Does that work for you?

Matthew Arnheiter – Vice President – Netsmart Technologies

That is perfect.

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

All right, we're ready when you are.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Perfect. So, good afternoon, I'm Matthew Arnheiter. I am the Vice President of Innovations for Netsmart Technologies and I do appreciate having the opportunity to talk to you about our efforts for integrating care and specifically around the Data Segmentation for Privacy effort that we have been involved with for over a year and a half now. I'll speak from the perspective of one of the largest providers of technology to behavioral health organizations.

We serve more than 20,000 private practices in the US, over 40 of the state-operated hospital systems in the US and approximately a third of both the community mental health centers and the opioid replacement therapy clinics or methadone clinics in the country. We participated in the creation of care coordination systems and the associated health information exchanges needed to connect behavioral health and physical health to some of the largest health homes even in this country.

So as a provider to these settings, we understand the complexity inherent in them and have developed the continuum of solutions to meet the needs for both the smallest private practices and the largest behavioral health organizations, the substance use organizations, social service, IDD and child welfare organizations out there. We have also developed solutions to allow for the secure exchange of information between these communities, and even for the larger healthcare ecosystem like acute care hospitals. And the challenge that we face in this integration is often balancing the open exchange of information with the protection of the sensitive information for clients that are served in these communities.

We understand that one key to bending the cost curve and providing an improved care to clients for this population is the integration and coordination of care, but often behavioral health and substance use providers specifically are eliminated from one of the vehicles to support this integration, which are the health information exchanges. So if an adult with Alzheimer's and diabetes consents to his records being shared on an HIE, they can do that and they can receive the superior care that can be delivered by coordinating that care and reducing the risk of medication interactions associated with the multiple medications that they are receiving. But a second person, one with diabetes and substance use issue, who has part of her treatment provided by a substance use provider, cannot consent to their records on an HIE without enormous burdens – administrative burdens on themselves and their provider. In most cases, the HIEs do not even want to receive that information.

So, data segmentation is designed to reduce some of this burden by finding a technological method of tagging the information as restricted, and associating obligations to this information. We welcomed this effort back in late 2012, quickly implemented designs into our CareConnect referral system and went live about a year ago with several of our clients down in Florida, both an outpatient treatment facility and an inpatient psychiatric hospital, as well as the 2-1-1 system in the area, the 2-1-1 system being a social service hotline down there. And the workflow that we build out was pretty simple, it was about five steps and I'll just describe kind of each of the steps at a high level.

So the first thing that we do is capture consent of the client in our EMRs and the consent states who the client is sharing information with, the start and end date for that consent. And any restrictions that the client wants to make on the information, meaning, they can actually specify what information they do not

want to share in this referral network, so they can eliminate the problem list or specific notes from that information being sent across.

When the client is discharged either from the inpatient psychiatric facility or being referred to the inpatient facility from the outpatient organization. They create a referral in our EMR solution. They select which provider they want to send the referral to and if there's an active consent on file, the information is formatted into a CDA document. During the generation of that CDA document, rules are fired to determine if restricted information is part of the payload and that information is tagged accordingly if it is restricted –

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

Matthew, I hate to do this, but we are holding everyone to 5 minutes, you are going to have to wrap up on this point and I hope that someone will ask you a question to let you continue with these steps, because this was exactly the information that we wanted.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Okay. Sure, so information is automatically tagged, sent across and then the receiving provider can look at that information, both from a restricted perspective, so they have a view only if it is marked as non-redisclosure. We specify the non-redisclosure statement within it and do not actually incorporate it into the structured data of the client's record, so it cannot be easily redisclosed from that EMR. So those are the five main steps of it.

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

Okay, terrific. I know you're going to get a bunch of questions Matthew on this, and my sincere apologies –

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Nope, I –

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

The – of our meeting time are making us be incredibly efficient today, so – but I know that folks will have questions.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Sure.

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

Who would like to go first?

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

This is David and I'm happy to go first again.

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

Okay, go ahead, David.

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

Drilling in a little bit to your five steps there at the end, I'm curious to know that when you allow for restrictions on what is sharable, is that a process that the patient sits in front of the screen and looks at the data and decides what to filter? You sort of implied that the patient was part of that process, how does that work?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

The patient's part of the process, but it's more the provider themselves marking the information. So we allow for the capture of any of the sections to be kind of redacted from the information being sent, or if they want to remove a specific note, they can do that. Sometimes that is done just as a general, they just don't want to release the whole list of problems, but they do want to share medications and things like

that, because they see the value of it. And other times, it's an all or nothing, so, it really depends on the configuration of our providers.

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

And then, just to drill in one level deeper, sometimes a patient might say, I don't want you to disclose my depression, but then they don't say anything about the medications and the medications obviously give away the depression, because of their focused use. Is that something that patients are expected to just understand or do you – the doctors talk them through that or does your system logically infer linkages at level?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Umm –

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

It's very hard to redact these facts in a way that makes it undiscoverable to the receiver, is my real question.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Exactly. So it's usually the provider walking the client through it, in most cases. We can restrict, because we know the relationships between problems and medications and other areas of our solution, but we also don't get into natural language processing to do restrictions of free-text search fields in our solutions. So, you're exactly right in your last comment, it is almost impossible to completely restrict that information from someone else finding it out. But, regardless of whether we send that information, if the client is tagged as being part of a program for 42 CFR Part 2 or substance use in general, we do mark the whole document as being restricted, and then the receiving provider can only see that information if they have the right rights in the solution.

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

Thanks, I have lots more questions, but I'll let somebody else go.

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

Yeah, thanks.

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

This is David Kotz can I ask a question?

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

Yeah, go ahead David.

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

I'm interested in this redisclosure constraint I guess two questions. One is whether the system itself has some mechanism that prevents the redisclosure or whether that's just an indication for a human to, please don't redisclose. And then second is, who decides or how is it decided that some particular piece of information should have that tag on it?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Great questions. To answer your first one, it's kind of two-fold in our solution, we both display it, because we have to as part of 42 CFR Part 2, to show the redisclosure statement on any information that they receive. So the CDA document has a big header in it when you view it if it's marked as non-redisclosure to say that statement as part of the regs. On the other side, we do not include that information, so if we receive a CDA document, we can parse that document and make it part of the clinical record, but we don't parse information that comes in with that redisclosure non-redisclosure flag. You can only view it as a complete document and that document cannot be sent out from the solution. So we both handle it from a user perspective and from a technological perspective in not allowing that information to be included anywhere.

Wes Rishel – Independent Consultant

Wes Rishel.

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

Go ahead, Wes.

Wes Rishel – Independent Consultant

You described the interview process, if you will, where a provider works with the patient to identify information at various levels of detail that they might not want shared. In your initial implementations, did you measure how long that took and how often that actually happened as opposed to it being a capability in the system that wasn't used?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

We didn't measure that, we worked with all of the clients. All of our clients – not all, but many of our clients are in the substance use, they understand the regulations inherently and do work with clients a lot to make sure that they understand the restrictions that they are put under for any information that they track in it. So, it's not necessarily as part of us as a technology.

Wes Rishel – Independent Consultant

One of the things that concerns me is that it's easy to build systems that recurse into incredible detail and it's hard to work with people at that level of detail. And I'm trying to understand the difference between the practical use of that kind of hierarchical tracking and the real use.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Yeah, I can easily do searches on there to find out. Most of our clients are probably just doing all or nothing in terms of the consent, they're allowing all of the record to go across or none of the record to go across, because the client chose not to share that information. Being able to dive down is an option of the solution, but I would doubt many people go walking each level of the care record to determine which shouldn't be included.

Wes Rishel – Independent Consultant

Thank you.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

This is Gayle I've got a question.

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

Go ahead Gayle.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

When a patient decides to disclose perhaps part of the information, but not all of the information, how do you deal with that? You said most patients go either in or all out, but when someone wants essential information, perhaps medication information but not the rest of the record done, how do you deal with that?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

From a technological perspective, that information is just eliminated from the CDA document being sent across. We don't put any mention that there is other information that is being in there and usually the providers are doing things outside of technology to talk with the other provider, to ensure that no harm is being done because information was removed from the record. But, we purely have that piece of functionality in there to allow for that case, but I think the more likely scenario that has been out there is that it is an all or nothing scenario.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

– is a nothing if people say, I don't want my information shared, but they have medications that would have interactions with other medications, is there any ability to handle that, should there be – what happens in those situations? Can you give us – do you have any way of letting other practitioners, other physicians who are primary care doctors or whatever, that there are records available should there be an emergency or something?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

From emergency perspective –

Gayle Harrell, MA – Florida State Representative – Florida State Legislature

– is there a break the glass kind of – ?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Right. So our scenario is typically the referrals not to handle emergency situations if a patient ends up decompensated in a hospital. In those cases we have worked with some HIEs to keep all records that we submit to the HIE as restricted, where no one can view them unless a break the glass is performed. But that is completely outside of the data segmentation perspective, it is purely a part of some of the HIEs that we have worked with.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

Thank you.

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

So –

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

– needed, oh, go ahead.

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

Yeah, I'd like to squeeze in a question David.

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

Please.

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

I – this is Deven. Matthew, what – since you have been operational for a year, I'm interested to sort of hear how the – how well this is sort of working, both with your clients and if you're aware of it, with the recipients of information from your clients who may be getting view only capability in circumstances where there – it's restricted data?

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

So from our clients, there has been great acceptance of it, mainly because the burden is pretty low. Just being able to track consents and being able to specify the rules in the system to say, if this whole program is restricted under 42 CFR Part 2, then every information we send out from that program is marked as it. On the viewing side, it's similar; clients have definitely liked the ability to get information electronically. They have received the information, often times weeks before they would have received a paper record.

It definitely is a key part of the referral process that we have performed and in some cases, it's saved some hospitals millions of dollars just because the patients that they are receiving that have substance use issues or behavioral health issues, typically are watched within that facility and they can't just release them. So the cost of care is actually high from the inpatient perspective and being able to send an electronic referral and get a discharge performed earlier in the process has saved some hospitals millions of dollars and ultimately provided better care to those patients.

So, it definitely is a huge need for this community, the challenge is really around how do we make it so that we can do it in a way that meets all the regulations and not put a burden on it. So, it's worked in our world, because we have a pretty restricted community. We know the EMR on the sending side and the EMR on the receiving side is able to understand the obligations. The larger healthcare community has not been able to participate in this, mainly because they haven't either picked up Data Segmentation for Privacy or they have not wanted to include this community within the larger HIE efforts.

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

This Dixie – I'm not sure David's still in the queue, but I'd like to jump in after him.

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

Okay, we've got to do it relatively quickly, but I'm going to let you both go. We're going to just eat right into a little bit of public comment here. Go ahead.

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

Yeah, Just drilling in on that last question or the last answer from Deven's question about you're describing a situation where both sides of the transaction know how to process the data segmented CDA. In those – and it's doesn't wor – and that was my question to clarify that you're not sending those to EHRs that don't know how to do it. But in your world, where they do know how to do it, and they receive a restricted, read only CDA, you said you don't parse it and you don't allow it to be forwarded. Has that generated issues so that they're looking at their structured summary of the patient, knowing full well that there's stuff that's not in there that's in the CDA they have to go find and read?

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

Yeah.

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

And they can't duplicate it into the structure without – unless the patient walks in and tells them face-to-face, in which case they can put it in there? Does that – we have really stum – struggled with that issue in the broader EHR community.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

I don't think they – so, any information is better than no information. So I think our providers have been happy to just get anything within the record. Obviously parsing it, importing it, allowing all the clinical decision support rules and med interaction checks and things to fire would be a better step. Unfortunately, that would be a next step and a bigger change, because every piece of data we would then have to allow for tagging in the structured record, which would be a change to every piece of functionality in our EMR. So we have not gone that far.

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

Yeah, that's our experience as well and that's a big set of changes that we've – but it's interesting to know that you are successfully doing it where they can't parse, that that's an acceptable compromise. That's good new – good information to hear.

Matthew Arnheiter – Vice President of Innovations – Netsmart Technologies

Yes.

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

Okay Dixie, go ahead.

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

Actually, that's exactly what I was going to comment on, especially where the CDA might include, to address Gayle's point, that it might include the meds, and you still would have to leave that information in the CDA, but it sounds like that's acceptable.

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

Or it's what best you can do.

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

Okay, thank you. Thanks to all of you and Matthew, thank you very much. Do we have Dan Levene from Cerner on the line?

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

Yes, this is Dan Levene.

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

Oh Dan, great thank you, sorry for the mispronunciation of your name the first time around. Are you ready?

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

I'm ready.

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

Do you have slides?

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

Yeah, the one that would be – that's exactly the one, right there, that's very helpful.

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

Okay, so this is the one for people who are not online, it's the SATVA Pilot, it's a very short deck, it's only a couple of pages, right, so we shouldn't be too hard to follow. Go ahead, Dan. I won't start your time until you start talking.

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

Okay, great. If I can advance to the next slide, that's where it really starts. Excellent. So one point of clarification, the agenda listed this as a Cerner pilot. The pilot is really from an organization called SATVA, which is behavioral health software and technology vendors, a group of vendors that meet regularly and have created – and decided to participate in this pilot. And also outside of this to put together some common expectations, standards and if possible, an implementation guide on how to do some of this exact stuff. We started that conversation before the DS4P Pilot and then rolled our work into that as well.

The current active participants are Cerner Behavioral Health, Valley Hope Association, who is a substance abuse treatment provider, and then some ancillary input as well from HEALTHeLINK, an HIE in Western New York. The status of this pilot is that we're continuing to enhance it and test it, there is no production use of it at this particular point in time. And in terms of real-world organization, Valley Hope as a substance abuse provider is building a consent manager based on what we've learned, to give their substance abuse treatment clients control over when and to whom their care information may be released. And also in April of this year, right now, actually, Cerner Behavioral Health will be releasing functionality in production that will incorporate DS4P for Direct and SATVA IG conformance for these things. So, can I get the next slide?

So DS4P via Direct is kind of a shorthand for what the SATVA Pilot does. We use the NwHIN Direct transport, direct messaging to transport CCDs. And it enables consent based disclosures of C-CDA documents that include DS4P compliant privacy tagging of entire documents and/or individually disclosed data elements and the tagging is both human and machine readable. These ultrasensitive documents are sent by the Direct transport with identical privacy tagging in the direct payload and metadata outside of a document itself so that machine processing of these things outside of the actual clinical data can happen as well. Conceptually the pilot separates the act of consent from that of disclosure.

So the consent is managed locally at each EHR system and recipient obligations are derived from the consent. And then those obligations are contained in all disclosures, all CCDs, conveying what the recipients may and may not do regarding disclosed information. So in a section near the top of a CCD, we basically state the purpose of use for the disclosed information and what obligations the recipient is expected to abide by, such as not reusing it for another purpose and not redisclosing it without further consent from the patient. So, this is – using Direct, it's well-suited for point-to-point, on-demand disclosure exchange. One of the great advantages, there's really no immediate technology updates required of a recipient to recognize and display an ultrasensitive tagged CCD, as long as they can currently display a CCD with an associated style sheet.

Because everything is embedded into this version of the CCD without compromising or stepping on any other aspects of the CCD, the human readable requirement from 42 CFR is conveyed to any end user that would happen to look at it. The only pre-requisite is a trust relationship between the sender and receiver, that the obligations that are conveyed in the disclosures will actually be honored by the recipient organizations, regardless of their standing under 42 CFR or any other privacy regulation. So that's really maintaining the status quo of what people have to deal with now, it's when this kind of disclosure on paper or in any other fashion, that the sender has to trust that the recipient is going to respect it in some fashion. Next slide, please.

Future things that we want to include in this whole process is to incorporate a version of the HL7 Consent Directive to be used in carrying remotely executed patient consent so that a non-42 entity can send a request to a 42 entity, with a consent form that's been filled out by the patient electronically. And that gives the 42 CFR entity permission to release that information back. We also would like to see some minimal message process indicator included in Direct messages so that we can mark things such as whether it's a request for a disclosure, whether it's a reply to a previous request. And this could be accomplished through extending XD metadata in the XDM package containing the CCD or the request for the disclosure. And these last items will require collaboration and consensus to be truly useful, but that's our aim and we hope that the construct of these items can and should be simple, to encourage quick and widespread adoption.

So overall, this ability to send via Direct is kind of what we call on-ramp to getting information exchanged. And then the next step, once receiving entities start to see this stuff, is that they need to be able to take a CCD that they've got that's marked with ultrasensitive information and then parse and bring that into structured data. And mark the structured data as well, so that future disclosures out of the receiving system don't inadvertently step on the obligation from the originally received information. Currently Cerner –

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

Dan?

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

Yes.

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

Dan, I'm going to have to ask you to wrap up because I've let you run slightly over time to get –

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

I've just have one more sentence to make –

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

Okay.

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

I was just going to mention that as a result of this also Cerner's Millennium product for hospitals is working on actually being able to parse this into structured data. And deal with it correctly, so that

throughout Cerner systems, this can be inputted as structured data, clinical support can be rendered off of it, but that redisclosure is not compromised.

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

Okay, thank you. Appreciate it. All right, who would like to ask Dan a question? I know I have one so I'll go ahead and start. So I want to go back – I want to sort of understand how the recipients deal with the restricted C-CDA that they would receive today. So they get it and they've got a system that wants to parse it and do the software checks around – for drug encounters, etcetera, etcetera. So what happens – you've got this sort of coverage of the consent to share the information in the first place, what then happens when the recipient receives it, in terms of both sort of machine or human interaction with it?

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

If they receive information that's marked as such, and they're already parsing that, they would need to examine for some extra entry information that we put on each piece of data, within the CCD to mark it as restricted in whatever fashion the obligations require. If they can't do that, they should stop the parsing until the point that they can do that – putting functionality basically keeps this as display only until they can. And our belief on the side of behavioral health – most behavioral health vendors and lots of especially smaller primary care facilities that our community-based customers deal with is that they're at the stage now where most of the time what's happening with receipt of CCDs is really just view only in the first place.

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

Okay, so just as a follow up, the description of the process to sort of the – is that – does the machine do that in terms of making sure that when the data is parsed, it continues to have that restricted flag or that's a step that you're taking in the future or that has to be humanly done? I didn't quite understand how that worked.

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

Well, right now, basically this is about creating and receiving messages that have the CCDs attached, so it's not about pulling it into the EHR, that's left up to each recipient EHR system.

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

Okay.

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

What we're hoping – what we have is the SATVA IG describes a generic and publically available way to do that it's not proprietary. Cerner is implementing it and we hope that others would adopt that or something similar as well.

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

Okay. Thank you. Questions from others?

Wes Rishel – Independent Consultant

Wes.

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

Hi Wes.

Wes Rishel – Independent Consultant

Can we get that description from SATVA IG?

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

I'm sorry can you repeat the question?

Wes Rishel – Independent Consultant

– you just talked about a public description from SATVA IG about the process of importing information once transmitted. I wondered if that’s a document that we could have sent to committee members.

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

The SATVA IG is a public document in – nearing final, but it’s in a draft form. I can ask the SATVA Board if they’d be willing to share that, I think they probably would.

Wes Rishel – Independent Consultant

Thank you.

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

Other questions.

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

This is –

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

Go ahead, David.

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

This is David. Dan and I have had a chance to talk about these issues inside Cerner, so I’ve been keeping quiet a little bit because we’ve –

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

I was wondering about you, David.

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

– already had this conversation. We’ve had this conversation a number of times, but I want to ask out loud a question that Dan and I have discussed internally and maybe it get queued up for when we have our SAMHSA expert tell us more about the question of the provenance of the discovery of non-redisclosable data. And the question that comes to mind is, if you receive the data through a non-redisclosure channel, you’re obligation to respect that is clear. If you receive that same data from a different channel, as we heard in our opening testimony, from Larry, that it’s not restricted.

And the question is, how is that supposed to work with structured data in the EHR future, where the sequence by which one discovers the data determines whether you can or can’t release it? And I’d just like some clarity on that when we get to that subject. Dan can comment as well if he wants, but I’m really just queuing up a question in the context of what he just pointed out.

Dan Levene – Director, Cerner Behavioral Health – SATVA Pilot Technical Lead

Yeah, real quickly, in the future, that’ll be the killer app for this functionality is to be able to deal with what we call rediscovery of sensitive information coming from sources that are not sensitive. And once you discover it from a place that is not sensitive, then you can – you’re much freer to deal with that information down the road, so, it’s definitely an important topic.

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

And I – I’ll just queue up the, let’s make sure we get the inverse of that. Let’s say you discovered it from an unrestricted source and then heard about it from a restricted source, does the restriction now trump the prior knowledge, and queue that for our SAMHSA expert.

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

Okay. I’m just – I’m taking notes on this one, David. Other questions?

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

I've been yelling about this one for a long time, so, you've probably got it in your notes already somewhere.

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

A lot of pent up demand on that one. Are there questions from other members of the Tiger Team? Some of you are either being really quiet or not fast enough. All right, well we'll take advantage of being a little ahead of time. Do we have Laura Young from Behavioral Health Information Network of Arizona on the line?

Laura Young – Executive Director - Behavioral Health Information Network of Arizona (BHINAZ)

Yes, I'm here.

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

Okay. Great. Now your slide deck, Laura, is much bigger.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Yes.

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

But you can presume that we can read the things on it that you don't necessarily want to take your 5 minutes to emphasize, so – but let's go ahead and get your slide deck up while we're teeing you up here. There we go and we're ready to start when you are.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Okay. You can go ahead and advance the...I'm Laura Young with Behavioral Health Information Network of Arizona. We are a behavioral health HIE in Arizona. We are community stakeholder owned. We have about five non-profit behavioral health organizations that are part-owners of our organization. We were formed as an LLC in – here in June 2013, last year. We are a statewide initiative doing specific HIE for behavioral health across the state of Arizona. Go ahead and advance to the next slide. Am I advancing or someone – oh okay, sorry.

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

– for you.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

I was going to say, I'm missing something if that's the case. This is our mission statement, I'm not going to read it to you, so you can go ahead and go to the next slide. Our vision is really, over on the left is Behavioral Health Information Network of Arizona, we are connecting various different kinds of behavioral health entities and also lab systems, pharmacies, crisis services. We also will seek to connect some health – hospital systems, but for the most part, we are connecting to the state HIE, which is HINAZ over there on the right. They actually have about 32 connections currently of various different hospital health systems, payer systems, the labs and PCP specialists. That connection is due to be completed in September of this year and will give us a feed of all the acute physical health data into the behavioral health HIE, both via CCD documents and then we're also going to be getting ADT – real-time ADT alerts from the hospitals so that we can alert down to our behavioral health providers. You can go ahead and go to the next slide.

Some of the key drivers behind why we formed our HIE, and these are, I'm sure, the same reasons a lot of us are doing the work that we're doing right now. But the big drivers really had to do with the integration between physical and behavioral health. And then here in Arizona, we have a really large behavioral health MCO contract, it's for 7 billion dollars for 5 years, and so we really wanted to make sure that we were part of that process. Typically, what happens is when those regional behavioral health authorities turn over, they leave and they take the data with them, and so we really wanted to make sure we were in

a position to have the data remain within the community and be community-owned. So, you can go ahead and go to the next slide.

The public versus the private HIE, probably we all know this, but public HIEs tend to focus a lot more on bigger volumes of data. And our private HIE, we have a lot more toolsets. We do a lot of workflow development. Our goal is really to have the data flow directly into the EHRs that the clients that connect with us are using, so that they don't have to use different portals or whatever, to get to the data that they need. And then we have a number of value adds that we – as well. You can go ahead and go to the next slide.

So why a separate behavioral health HIE initiative, again, you all know about the complicated federal laws around 42 CFR Part 2 and we felt the way to address those issues by having a closed behavioral health information network. There was a lot of – in Arizona, so it was a good setting for us to do this. Again, it allows us to maintain the integrity of the behavioral health system here, especially with those regional behavioral health authorities that are turning over. It provides a platform for emerging business opportunities amongst our local behavioral health organizations and then again, the behavioral health providers are really owning this technology. You can go ahead and go to the next slide. You guys already know probably all of the HIE benefits, so I'm not going to read these to you and go ahead and skip on to the next couple of slides.

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

You have about two minutes Laura.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Okay, I'll keep going – the next one also. Our network is made up of behavioral health providers. We do have, as I mentioned, HIE connections. Patients and consumers are engaged. We do seek to connect with primary care, laboratory companies and specialists. We do hospital systems where they're not connected directly to the HINAZ system. Go ahead and go to the next slide.

Our solution has a lot of these different aspects, some of them are on our roadmap, and some of them we are already doing. But we are doing various different types of protocols and we support a number of different things, and so, I'll let you just read that and we'll go on to the next slide. We exchange structured data elements that are the demographics, labs, medications, allergies, diagnoses and then a number of clinical documents, which are pretty critical for behavioral health. This is just a small list of the vast number of types of clinical documents that we could exchange and these are in a PDF format. You can go ahead and go to the next slide.

Sorry, I have to click through a couple. Here, our current technology – we're using a NextGen HIE platform because a number of the NextGen – and that number of behavioral health providers here in Arizona are on the NextGen platform, so it made sense for us to do that. And then we're using Mirth to expand on that solution. We have a dedicated HIE stack, we're using Mirth Connect for our interface engine and that is what allows us to have all of the expanded capabilities for connection. Topaz Information Solution is the NextGen reseller here – behavioral health reseller here in Arizona and we're partnered with them to do a lot of the customization that we need. And then we're using ClearData for our hosting. You can go ahead and go to our next slide. You can go ahead and skip this one.

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

Yeah, Laura, I'm going to – you are technically out of time, but I think you're getting to the pieces that are going to be of particular interest to the Team.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Yeah.

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

So I'm going to give you another minute. Thanks.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Okay, yeah, let me just run through this consent management real fast. I think you all know about the difference between opt in versus opt out, so you can go ahead and skip that. Privacy and consent, we're an opt out state in Arizona, but we are operating – our HIE is operating under an opt in model. We do require clients to specifically agree to share their data from one provider to another, so each provider they visit, they do have to sign a consent agreeing to share their data out to the rest of the network. And all of our data is treated like Part 2 data, so if anybody does not want their Part 2 data shared, then they are opting out completely of the HIE, we don't share it, we don't segment data. Go ahead and go to the next slide.

Our consents are captured electronically at the point of care. They are valid for 365 days and then we require a new consent. Patients can revoke them at any time; they must do that in person. The consent is an all or nothing, again, as I mentioned, we're not doing data segmentation, so it's all their behavioral health data plus everything else we have or they are choosing to opt out. Go ahead and go to the next slide.

We do require additional consents of minors, age 12-17 and they can revoke without their parents. So anytime a patient or client's age changes to 18 or the age of 13, we do require a new consent. And we do allow break the glass, regardless of consent status, for valid emergency situations, and those do need to be documented and we do notify the patient that that activity is taking place. Go ahead and go to the next slide.

This is a really quick, I'm sorry, kind of use case. If we have a participant that visits and agency, they send their consent, it allows that data to flow out to the rest of the network where there is a treatment relationship. Let's say that that same patient decides to visit a detox center a week later and they choose not to share that detox data. The detox center would receive the data from the original agency, but they – the detox data would not flow out to the rest of the network. And that way we give the clients some flexibility in terms of where their data is being used. You can go ahead and go to the next slide.

You can skip this one, go ahead and skip this slide, I'm sorry we don't have time. Yeah, I think that's pretty much everything so if you want to go ahead and kind of skip to the end, I think that covers most of the things I needed to go over.

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

Okay. Again, our apologies, what you're doing has a lot of pieces to it and unfortunately, in 5 minutes, you can only cover so much. But, we got a lot of good information, I think. Questions for Laura? So I – I'll start off with one. What – how many providers and other entities are enrolled in your private network? And so what does that mean in terms of sort of your coverage of the state and what happens with providers who are not in the network, it sounds like they may not necessarily be able to receive or share this data.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Yeah, we're a relatively new initiative so we just completed our pilot phase in the past few months and so we are poised to sort of time this with the regional behavioral health authority contract that went live April 1. So we do have two other agencies that are going live within the next month and then our state HIE connection and then we have several other organizations that are in the queue. So really right now we're only live with a couple of organizations and really, we're working through a lot of the procedural concept and we've gone live with the consent management and we're working through that. So I can't really give you any hard and fast numbers right at the moment, but ask me again in a year and I can give you some better information.

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

This is Leslie Francis and it's a similar kind of question, I think. But I just want to understand how this relates to the other HIE connections in Arizona. So if somebody's a primary care physician, for example, would they in any way have access to this or is it only among behavioral health providers?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Yeah, so we have a partnership with the state HIE and really, they're not doing any behavioral health. So, if you are a behavioral health provider, you do need to connect to our HIE. So for the non-behavioral health providers, it act – choose behavioral health data. We're working it through – that project with the state HIE, where we would have a mechanism for those providers to capture the consent that's required to receive that data and then that data would flow from our HIE to them.

So, that is kind of Phase 2 of our project – state HIE. The Phase 1 is really for us to get data from them and into our behavioral health HIE and then the second phase of that is the – any primary care physicians that are connected to the state HIE could get data. And then potentially they could also opt to purchase a subscription with us independently of the HIE if they wanted to also gain access, so there are some options there.

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

So I can imagine a patient wanting to share information among behavioral health providers, but not with the general HIE. Will there be anything like that?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Say your question again, you can imagine that they'd want to share behavioral health data with other behavioral health providers, is that what you said?

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

Yeah, within the behavioral health network, but not necessarily across the entire HIE.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Yeah, so our HIE is a closed network of behavioral health providers, so this organiza – that participant who did not want to share their data outside of the network, they wouldn't – the data does not flow without their consent. The only way that that would happen is if they chose to execute a consent, let's say they were at their primary care physician's office and they disclose to that primary care physician that they have some additional data and that physician wanted to retrieve that data. They would get a consent at point of care to get data from our network. So it would only be with the patient's consent.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Um hmm.

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

Go ahead, Larry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you. So, I think on one of the slides I saw you flash up something about patient involvement – participation in this as well. Do you currently or are you envisioning that patients will have direct access to the network?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

So our patient involvement is in the initial stages of the project is really to kind of get consumer input into the process and try and understand what we can do with the consumers in mind. But our later roadmap does include a patient portal, we do want to be able to have patients have the ability to look at their personal health record that we have on file at the HIE and potentially execute and/or revoke consent through that portal. So that is in our roadmap.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Have you thought through how you would authenticate those patients to be able to do that?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

We haven't, I haven't – we haven't gotten to that point. I mean, there's – the Mirth platform that we use has a patient portal product companion, and we'd have to sit and work with that organization. But it would likely be an out of the box type of solution that we made sure has the proper authentication methods, and I'm pretty sure that most patient portals that are – have any kind of market share, probably thought through that process, at least I'm hoping so. So I'm hoping that's not a problem that I personally have to solve, but we would want that included in our patient portal product.

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

I have a question – this is Dixie.

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

Go ahead Dixie.

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

Since this is a private network, are there any restrictions – do you even use the DS4P protocol or are there any restrictions on how information can be used among behavioral health institutions? It sounds like this pilot is just how to build a private network.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Yeah, there are no restrictions on how they can use the data. Now one of the things that we do when we sit down with a new organization that's going to connect to us, we do a comprehensive evaluation with them in terms of what data they're willing to share with the rest of the network. And in some cases, there might be a relationship with – two organizations within the network where they may be sharing additional items. One of the examples I can think of is progress notes. Progress notes typically most of our organizations are not comfortable sharing with the rest of the network, but there might be a valid reason why they need to share with one organization and in that case, we actually can transmit progress notes for patients that they share between one – only two clients. So we do have some flexibility in terms of the way the data can be shared, but in terms of the way the data is used, there are no restrictions on it because all of the organizations that are participants are behavioral health organizations. So, for the most part, these organizations are already receiving this data today, they're getting it via FAX or they're getting it somehow else, this is a way for us to streamline this and get this data to them in a – fashion and more comprehensive. And in most cases, straight into their EHR where it's connected straight to the patient record, it saves on them having to scan it in and all of that.

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

So that would be Phase 2, right? Phase 2 is where you get it into their EHRs.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

No, actually that's now. So the data goes right straight into the EHRs today. So, some of it goes in as structured data and some of it goes in as a document, depending on what type of item it is. So, that was the slide that I have that had things like demographics and diagnosis, allergies, meds and labs. Those all go in as structured data elements, right into the EHR. And then there are documents that just go in as documents, but they go to the EHR directly.

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

That EHR, the behavioral health's EHR, right.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

The – whichever EHR that the client is using, yeah.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry.

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

– it's not – you're not yet pushing it out to the general clinical practice physical health side of things, right?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

No.

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

Okay. Got it, okay, and thank you.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Now in some cases, some of these organizations have both physical health and behavioral health, and they are connecting to us and in that case, we would be pushing it out to their whole organization in that instance.

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

Oh, okay.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry, quick question.

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

Yeah, go ahead Larry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

So I – so in order to make that happen, I believe you have an MPI that helps map the identifiers so that they can load this in and – can you confirm that you do have an MPI for the community?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

We do, yeah, absolutely. Mirth actually has a pretty comprehensive MPI that we are using as part of our HIE. So that is absolutely – it was on one of the slides I think we breezed past it really fast, but we do have an MPI.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Right. And so because you're dealing with behavioral health data, do you have the MPI tuned differently than you might normally have, do you think? In other words, is it – have you specifically reduced the chances of mismatching patients? Have you thought about that?

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Well, yeah, we – our patient matching is – critical to us, so we have spent a lot of time thinking about how we're doing patient matching and having enough points of match. The nice thing, or kind of bonus thing within the behavioral health community, because so many of these clients are regional behavioral health authority clients, they actually have some unique identifiers that they're using because of that. So we actually have some additional data elements that we might not have had if they were not behavioral health clients. I think where the trick is going to come in is when we receive data from outside of our network, for non-behavioral health data, the physical health data, matching that data and making sure that that goes where it needs to go. And we're still building that interface, so we haven't done the testing on that yet.

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics

This is Leslie Francis, if I can inject – interject again. I would like when we have a discussion with the SAMHSA people to know what, if any, might be issues about the within organization flow between behavioral health and other parts of the EHR.

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

Yeah, me, too.

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

Okay.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

And, I'm sorry if I didn't understand that, so you wanted to know how the data flows between different parts of the EHR?

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

No, I think Leslie was – Leslie Francis, one of our Tiger Team members was making a note for a future Tiger Team call when we –

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

Oh, okay.

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

– you don't have to worry about it Laura. If you have a thought on that question, we'll definitely take it. You can also feel free not to answer it if you don't want.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

I didn't really necessarily understand the question, so I couldn't answer it for you.

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

Okay. Fair enough. Any other questions for Laura? All right, well shockingly we are slightly ahead of schedule. We may have some of our previous persons who presented to us still on the line, and we had to cut off their questions pretty quickly. If there is anyone on the Tiger Team has a question for somebody that they didn't get to ask, who may still be on the line, we can try to do that now.

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

I do. This is Dixie.

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

Okay.

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

For Matthew, I would – he sort of summarized his steps 3, 4 and 5.

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

Hey Dixie, before you go into the question, let's make sure Matthew's still on the line.

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

Okay. Yeah.

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

Matthew, are you still on? Yeah, that's what I was afraid of.

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

Yeah, I'm sorry.

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

What was the question anyway because we can follow up with him and see if we can get him to answer it by email.

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

I'd just like to hear what those other steps were, he kind of went steps 1, 2 and then because of timing –

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

Oh, no, I think he finished them, but we'll ask – let's see if we can get him to clarify the five steps in writing, so we have them.

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

Yes, that would be great. Thank you.

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

Any other –

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

And if we have time, I was going to ask Laura to answer the question about, within these institutions that do have physical health and behavioral health, on her network, on the behavioral health network. What do they do to provide the – or do they do anything to tag the data or any – do they in any way, in be – tag the data as behavioral health when they integrate it with an EHR.

Laura Young – Executive Director – Behavioral Health Information Network of Arizona (BHINAZ)

They don't. I don't think the EHRs are really there yet, in terms of being able to have that ability, I mean there are things that we can do within – and I shouldn't say we, because I'm not in the EHR itself, but the EHR, there are things that they can do to tag certain types of data. In particular, the NextGen system, they use customized templates, so I think they have ability to have data collected and kind of segregated, if you will, in terms of what data is being collected for what reason. I don't know that it's necessarily tagged, per se, but – because I know the EHR doesn't necessarily support that yet, I know that's the direction that they're going. But I think for the most part, the goal is really to be able to have that, the data that they need on both sides, the physical and the behavioral health side, that they need when treating a client. And so for that – in those instances, they really are collecting consent and permission to be able to do that, so that they can have a comprehensive look at the patient record when they're providing care.

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

Thank you.

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

Great. And anybody else? Okay, well, we are about two minutes away from where we had designated public comment on the agenda, so I think we can go ahead and open it up to public comment. But actually, before we do that Michelle, I want to say that for our next call, we do have one or two people who we couldn't squeeze onto the agenda for this call that we'll hear from and then we'll be able to spend the rest of the call in discussion. So at least a full hour on discussing what we've learned here. We'll try to get some follow up with the witnesses we heard from today in terms of some things you all have asked for, in addition to making sure it's clear to the SAMSHA representatives what kind of clarity we need from them to have that discussion. So, we will do that. And our next call is on April 28. Any other questions before we move into public comment? Thank you everyone for your patience with again the speed of all of this, got some really good information, though, really incredibly helpful. Okay Michelle, go ahead and open up to public comment.

Public Comment

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

Okay. Operator, can you please open the lines?

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're 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, LLM – Director – Center for Democracy & Technology

All right. Terrific. In a call that I thought was going to run over, we actually ended early. Thank you all and talk to in less than two weeks