



HIT Policy Committee Consumer Workgroup Final Transcript April 20, 2015

Presentation

Operator

All lines are now bridged with the public.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Consumer Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. We've also invited members from the Privacy & Security Workgroup to join today's call, but I will first take attendance from the Consumer Workgroup. Christine Bechtel?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I'm here.

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

Hi, Christine. Amy Berman?

Amy Berman, RN – Senior Program Officer – The John A. Hartford Foundation

I'm here.

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

Hi, Amy. Brad Hesse?

Bradford W. Hesse, PhD – Chief, Health Communication & Informatics Research Branch (HCIRB), National Cancer Institute – National Institute of Health

I'm here.

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

Hi. Clarke Ross?

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Good morning.

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

Good morning. Cynthia Baur?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

I'm here.

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

Good morning. Dana Alexander? Danielle Tarino?

Danielle Tarino – Lead for Consumer Education, Health Information Technology Team – SAMHSA

Present.

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

Good morning. Erin Mackay?

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

Here.

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

Hi, Erin.

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

Hi.

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

Ivor Horn? Kim Schoefield?

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

Here.

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

Hi, Kim. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi, Leslie. Luis Belen? MaryAnne Sterling?

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

I'm here.

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

Hi, MaryAnne. Nick Terry?

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

I'm here.

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

Hi. Phil Marshall?

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

Good morning.

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

Good morning. Teresa Zayas Caban? Theresa Hancock? Wally Patawaran? Wendy Nilsen? Will Rice? And from the Privacy & Security Workgroup I saw or heard Kitt Winter.

Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration

Yes, here.

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

Hi, Kitt. Are there other members from the workgroup on? Okay, so from ONC do we have Chitra?

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

I'm here.

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

Hi, Chitra. Julie Chua?

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Here.

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

Kathryn Marchesini?

Kathryn Marchesini, JD – Acting Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Here.

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

And Rose-Marie, and I'm sorry, I'm going to butcher your last name, Nsahlai?

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I'm here; that's fine; Nsahlai.

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

Anyone else from ONC on the line? Anyone else that I missed? Okay, I'll turn it back to you, Christine.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I was totally on mute; it's a good thing I caught myself. So, we have a full house today, thanks everybody for joining us for the beginning of yet another marathon. So let's see, what I'd like to do is give you a little bit of a preview of where we're going. Let's go to the next slide. We know who we are, keep going. Okay. So, all right, so what we're going to do today is go through objective 5 that's been proposed by CMS and ONC as part of Stage 3 of the Meaningful Use Program. If we have time, we're going to try to get to some related certification criteria around VDT; we have some experts on the phone to help us with that as well because some of it gets pretty technical. So, that's where we'll focus now.

Our next call, which is going to be 4/28, hopefully we will have gotten through enough of the content today to launch into objective 6. Those are the two objectives we've been asked to review. If we don't get to it on the next call, that's okay because we went ahead and crammed as many phone calls into your calendar as we possibly could, and here's why. So just to...here's the timeline backing up. May 12 is when the Health IT Policy Committee will meet as a whole to consider feedback from all of the workgroups that it has charged with looking at the Meaningful Use NPRM.

So backing up from that date, we have one, two, three, four calls that we can potentially use. We may not need all of them, but we wanted to have them. So that's Tuesday April 20 followed by Thursday April 30, and then May 6. So if we can get through in those three calls that will be perfect. On May 7 the Advanced Health Models Workgroup is going to convene, and I think they've...and Michelle will correct me if I'm wrong, asked all of the other relevant workgroups to join them as kind of a first cut of sharing the workgroup reactions across all of them. So I would expect that we would present or I would present on your behalf, objective 5 and 6 comments and then from there...

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

Hi, this...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...Michelle, were you trying to say something.

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

It wasn't me.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

This is...hi, this is Ivor. I apologize for getting on the line late; it took them a while to connect me. I don't have the 28th and the 6th calls on my schedule, did you guys send out an announcement for that and I somehow missed it?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

We did, so we ca...we will follow...

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

I'll look for it then, I won't hold up on...I won't hold the line up for that then; I'll look for it and get back to...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, I'm looking at it, it went to your Gmail, so, I see that on the 20...I looked at the 28th call.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

Okay great, thank you.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, these are...most of these I think are at noon. I was feeling guilty about our West Coast friends, so hopefully...

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

Yay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...we'll...you're welcome, Phil. Umm, so, hopefully we'll have...continue to have great attendance. Okay, so that's kind of the line-up. Any questions about that before we dive into our discussion? Okay, so, next slide.

So just as a reminder, we're commenting as the Consumer Workgroup, and you guys know that our charge is to help to shape policy that engages consumers and families in their own health and their own care; to enable those consumer-provider care team and services and supports team partnership that are supported by health IT and then also to elevate consumer voices in shaping health system transformation.

Okay, so here's kind of a snapshot of objective 5. So, it's got a couple of measures in it; the first is around the...what we call the VDT, today's VDT, view, download and transmit, which is most commonly today offered through a portal capability, although that is not a requirement in Stage 2. So the measure here is for 80% of unique patients that they would be provided access to health information within 24 hours of availability to the physician practice. So that's a jump up from 50% and a jump up in the timeline in availability; but it also adds not just the VDT as we know it, which is again commonly through a patient portal, but specifically using an ONC certified API. We had a big briefing on APIs, that that would be an option so that physicians actually would not have to implement a patient portal, if they didn't want to, they could simply say, here are the two, three, four Apps that utilize the API that I'm certified to and you can use any of those Apps to download your health information. There's also a measure around patient-specific education resources and there are some exclusions. Next slide.

Okay, so, what I want to do is call your...so I think we should start by talking about measure 1, unless anybody has objections to that. But, what I'd like to do is call your attention to some of the resources that were provided to you in email. So the first is a word document called CWG Stage 3 objective 5 comments; this is a table that Chitra put together with a lot of help from the National Partnership because God bless Erin Mackay and her team.

You also have a separate document which was a summary that the National Partnership did that I suggested be sent to the group because it's a good comparison, at a summary level, of what was in Stage 2, what was proposed in Stage 3 and what the Policy Committee originally proposed for Stage 3. So it highlights the changes across those and hopefully makes that 300 page rule a little bit easier to digest.

So the table that I'm talking about, again that's CWG Stage 3, objective 5 is kind of a listing out of that with a place that you can comment on the bottom, if you like, but we really wanted to have a conversation today about this content. So, what I'd like to suggest is that we first talk about proposed measure 1, which is the 80%; I think we should start with the threshold and then move into the...a discussion of the API issues.

I have a ton of questions around the API stuff; I'm sure you guys do as well. We have some technical experts on the phone to help us and you'll see that the next slide, although we don't have to go to it now, actually lays out some specific questions that CMS and ONC propose that they need some comments on. But before we can really get to that, I want to have a discussion about first the threshold, going from 50% to 80% and second, the API discussion. So, questions, comments; the floor is open.

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

Christine, it's Phil; a curiosity clarification. What does it mean to give a patient access? If somebody has a portal that a patient can go and register on their own free will and that's available to all patients, does that qualify? Or does it mean that credentials have been assigned and given to patients?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Umm, anybody's welcome to correct me but my understanding is that you have made the capability available and there are some general instructions for how to go about getting signed up, but you do not, at least in Stage 2 and I don't think they're proposing this in Stage 3, you don't have to get 50% or 80% of your patients to actually sign up or issue credentials, but you do need to make sure that it is available to at least 50% of your patients, the data is there and there are some general instructions somewhere about how to do that.

There is a second measure, which we will talk about, it's part of objective 6, that has to do with using the actual...you know, actually logging on and viewing and there...that's a whole different, I think, probably pretty significantly large discussion for this group because there were some changes that CMS has suggested in a different rule that have got people pretty much ablaze. But hopefully that answers your question, Phil.

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

Yeah, I think it does, but I have a follow on question; so if it's just simply making it available and it's not as if providers can pick and choose those patients that make it available to, they either make the capability available or they don't; it's either 100% or 0%, why does it matter if it's 10, 50, 80; if you make the capability available, really one person having access to it means everybody does. So why is the percentage important in this case?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So that's...I think that's more of a comment than a question. It's my opinion, and I would love for others to weigh in on this, but the threshold going from 50% to 80%, I don't see a reason why that matters at all because I think if you have made the system capable and available, and the data is there for 50% of your patients, you had to do it for 100% of your patients more or less so, I feel like this isn't particularly meaningful at all. That's my opinion; what do others think, including you, Phil.

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

This is Nick, Christine, I thought that when I first read it, but I wonder, in fact, whether the key is the within 24 hours piece.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That's a different piece and you're right about that, that is moving from 4 business days in Stage 2 to 48 hours; so that's good, in that regard. I do agree that's a difference.

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

No, my point was the...that maybe you can't make a 100 per...you can't make all of the records for 100% of your patients available within the time period and therefore...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Ah ha.

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

...the measure is only that you have to make 80% available during that time period; maybe I'm misreading it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

What do folks think?

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

I think that's correct, I think that's a correct reading from what I see here on the numerator, but still, all the same I think the point still stands is once you have a process in place to either make records available or not, it's not as if you then pick and choose which ones that aren't going to be available in that timeframe, right? I think.

Clarke Ross, MA, DPA – Public Policy Director – American Association on Health and Disability

Hi...Clarke Ross...

Will Rice, MBI – Director Health Informatics – Walgreens/Take Care Health Systems

Hi, this is Will Rice. Yeah, this is Will Rice, I think the issue is really more process oriented and not technology is that the 24 hours for a use case would be that lab results are made available to the provider. They may, in fact, not have within their workflow, they may be offsite, they...you know, for a variety of different reasons they may choose to...they have not had a chance to review those and incorporate them into the chart; so I think the key is the timing issue. It could be that for clinical reasons the provider has reviewed them, but is, because of the sensitivity of the results, maybe wanting to not just make them available, but really reach out to the patient to ensure an optimal education around the results.

So, I think that...you know, there's...I think it's inappropriate to allow a period of time, a holding period, for the provider to have clinical judgment in terms of releasing those into the medical record and therefore available on the portal or available in whatever capacity it may be. But I think it's ensuring that they are not overly delaying those, but giving them an appropriate bandwidth period to review those results.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And that...and the 24 hours being the appropriate timeline is what you're saying, Will, right?

Will Rice, MBI – Director Health Informatics – Walgreens/Take Care Health Systems

Yeah, I mean, there obviously the focus is to move it from 4 business days to 24 hours so they're getting to closer to near real-time so that the provi...the patient has near real-time...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yup.

Will Rice, MBI – Director Health Informatics – Walgreens/Take Care Health Systems

...same access as the provider, but I think because of the clinical judgments perhaps needed by the providers, it's allowing for some...a little bit of a judgment period.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Got that.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children’s Hospital

This is Ivor. From the provider perspective I have a question about sort of, you know, if you think about the full spectrum of provider capacity, is this providing enough time, have they taken a look at the landscape enough to appreciate whether providers on the lower end of the spectrum will be able to meet this 24-hour deadline just from a workforce perspective and what that would require? And this is just, I mean, this is me asking as a provider who’s in a large system that should be able to do this, thinking about the provider who may be in...not in a large system and it requires man...you know, really basic office manpower, if that’s something...if they’ve done sort of background information to figure out if that’s sort of doable?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well I can’t speak to that obviously from ONC’s perspective, there’s something that makes them think it’s doable I think or they wouldn’t have proposed it. There are definitely a lot of facilities now who are releasing results instantaneously to consumers. I think the concern that this...since this is the Consumer Workgroup is we do need to think about what’s in the best interest for consumers and that includes a consideration of providers’ ability to succeed without creating some unforeseen issues there. But that’s the best I can answer that question. I don’t know of folks have other thoughts.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Christine, this is Leslie and in general availability means that the information has been accepted into the chart. So if there is a period where someone’s transcribing, that might happen a day later and then once the transcription is complete and it accepted into the chart, it’s available. So in this...so the workflow in general would be, a result comes in, it’s coming into an inbox, it’s reviewed by a provider. When the provider reviews it and puts it into the chart, it’s 24 hours from that date; so there’s a lot of time to review within the workflow.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children’s Hospital

Okay, sounds good.

Amy Berman, RN – Senior Program Officer – The John A. Hartford Foundation

This is Amy Berman. So I have a question about this and I speak from the perspective of a person who lives with Stage 4 cancer. There are systems, major health systems and OpenNotes that are in real time showing the information as it’s entered into the system, it is in the patient portal; there isn’t a difference, you know, as it’s in so it is. Cleveland Clinic is one of those big systems and they’re not getting any pushback.

This still does not preclude the conversations that providers would typically have, but they’re not seeing any ill effect, and I’m trying to understand is there a difference; are people translating the information into humanese or are they simply showing that the lab test came in, it’s normal/abnormal and if it’s that, then I’m not sure what the pushback is to have an additional period of time to have it show up. Because I’m not sure why that would mean that you need to think about conversation and what happens if that conversation doesn’t happen and...so, I’m just not kind of understanding the nuance of why you wouldn’t want it to show up in the portal that a test has come in.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

In real time, Amy, is that what you’re asking?

Amy Berman, RN – Senior Program Officer – The John A. Hartford Foundation

If this is...in real time, absolutely.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, in most...many organizations are doing that as soon as its available, again, it's when it's accepted into the chart and it's made available immediately and that exception, that period for the provider to review, say yeah, I've seen that, hmm, I'm going to call somebody is part of that process to accept and then it gets provided. So I think the 24-hour potentially is that allowing for a weekend where we got that on a Friday, I want to call somebody. I can't get through to them, I'll call them again on Monday, and so it just is some sort of cushion for those that don't have it. The organizations that are providing data, they find very quickly that it's better to do it immediately, but that's after they have the workflow in place and they understand how to accept the information and call people in a timely manner.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

Right, and this is Ivor, yeah, I don't think it's the pushback of providing the in...I mean, from...my question is absolutely not from the pushback of providing the information as quickly as possible, my...and it's not even a pushback, it's really a question of making sure that we are, you know, that we're providing and thinking about workflow challenges that may occur in some of those situations, to make sure that people have the capacity to do it in a timely manner. It's not a pushback for information at all, it's quite the opposite, it's saying, are we making sure that people have the capacity to do this and are we thinking that through to make it successful for people to be able to meet this goal.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so it's Christine, let me...what I wanted to do is try to clarify what the group is saying so I want people to tell me, agree, disagree. How I think I would characterize the comments so far is number 1 to clarify that our interpretation is that the big change is that information would be available within 24 hours to 80% of patients. My question is that does that give them the ability to hold back 20% on 24 hours, right? So that's...I'll put that out there as a question. But generally there is strong support for the timeline; some workgroup members really question why it's 24 hours and not immediately available simultaneously and whether that should apply to all patients. Is that an accurate characterization of where the workgroup is at or is there anyone that has concerns with how I've characterized it?

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children's Hospital

I don't have any concerns with how you've characterized it, my question for them is, as people have said, it's like I don't understand the 80% versus the 100%. That...I...for me I want clarity of why they chose the 80%.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

They're not going to give you clarity, Ivor, just as a matter of course. They'll give you clarity when they make their decision in the rule, so we have to...we, I think, unless folks from CMS are on the line or ONC and want to explain it to us, I don't think we're going to get clarity, so we need to make a comment that basically says, what's underlying the question, just from a process perspective, so we can suggest if you...you know, if you're thinking was this, then we think this, but we need to have a comment. Does that make sense?

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children’s Hospital

I think my comment is more in aligned with just there was some nuance in interpretation that people brought up in the...and I don’t want to, because this is a minor point and I don’t want to belabor it, I’m...it’s very, very minor and doesn’t change anything, it’s just a matter of me...helping me to understand a little bit...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children’s Hospital

...what they meant in the 24 hours and I can’t even remember who the person was that made the comment of the nuance that it was really about the 24 hours and not about the 80%.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right, so in the past I guess what I can say is, the way that the Policy Committee suggested thresholds was looking at, what was the minimum threshold that if you did it for this number, it basically meant you were doing it for everybody. Or if you did it for this percentage, you had enough of a workflow in place that if it was valuable to you, you would expand it to everyone; that’s how we always chose the percentages, but I can’t speak to CMS’s logic in this. So hopefully that helps.

Ivor Horn, MD, MPH – Medical Director, Center for Health Equity – Seattle Children’s Hospital

Thanks.

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

Christine, this is Erin; I have a related question or issue.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Um hmm.

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

So, as I read it, providing access means that, you know, the provider has to give the patient any necessary instructions or user identification information, whatever they need to either be able to access their data through the API or view, download, transmit it. And I know that the piece about sort of the whether or not patients actually take advantage of this capability, that’s something we’ll discuss in objective 6.

My question is, I don’t...as I read it, there’s no sort of measure of attestation that providers have to go through to document or demonstrate that they have given 80% of their patient population these instructions or user identification information and I’m wondering if the group thinks that’s something that’s missing from the current proposal? And also just a question as to whether maybe that’s why they chose the 80% because, I don’t know, it’s hard to...it’s...because they have to count how many people they give these necessary instructions to, I don’t know.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, so the w...I think the answer is probably that they would continue the attestation process under...that they'd have under Stage 2, which is how you are demonstrating the attestation. Tell me if I'm wrong Erin, I'm not sure they usually outline all of those details in the NPRM or the final rule, that they leave those to the CMS tip sheets to really figure out, okay, if this is the percentage and this is the measure, how are we going to require the attestation, that's in all those tip sheets, right?

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

I think you might be right, I guess I'm just...I want to be sure that there's...that we're somehow demonstrating that this information was given to 80% of the population.

Dana Alexander, MA, MSN, NP, BSN – Vice President Integrated Care Delivery & Chief Nursing Officer – Caradigm

This is Dana Alexander, that's my understanding as well, too, is that they are required to attest and demonstrate to this 80%, I just...

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

Okay, all right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And this is Leslie and maybe the big point there is that because you've turned it on, you provide it to 100%, but if you've not communicated it to anybody...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...who knows that it's there; so leaving it at that high threshold would then require some additional communication process from the providers to let the patient know it's available. So, I'm kind of rethinking, I was on well, what does it matter whether it's 30% or 100%, it's just on or off; it's really the com...wanting to encourage the communication. So, if we leave it at 80% and then state that our comment should include communication with patients around the availability of the portal.

W

Um hmm.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that would be important.

W

And Leslie...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so let me give you some quick information before we get too far down the road here; okay, and that is the...here's the current way that it is measured. So the denominator is the number of unique patients seen by the EP during the reporting period or I suppose the EH; the numerator is the number of patients who have timely access, within 4 business days, of their health information that they can view it, download it or transmit it to a third party. So, it's just the number of patients who have timely access and for most people this is everybody, right? Does that make sense?

So it's...that's it, where the...where I think the issue comes into play, and we can do a little bit of talking about that now if you guys would like, in terms of how you force the practice or the hospital to communicate with patients about it. I think the way, and Leslie you'll remember this, the way we were thinking about this in Stage 2 was, well if we just said that 5% act...you've got to get 5% of patients to actually go online and use it, that will mean, by default, that the practice or the hospital has to communicate with their patients about it. That they have to build it into their workflow in ways that make, you know, that really result in 5% of your patients going online.

So this is supposed to be a two-part threshold and I think part of what you guys are saying is, look it's fine to provide access to 80% of your patients and that the data is available within 24 hours of it being available to a practice, which could be 24 hours of the visit or the admission or discharge as well as 24 hours of receipt of lab data, right? And then from there we would look at what's the incentive to get that in play; and that's, I think, what our comment would be here which is, okay, 80% is fine, but what really matters is that it's not a passive, I just turned it on, it's an active, we are using it together. Is that accurate?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Christine, this is Cynthia. So I'm just wondering at what point during the discussions over the last several years of the requirement or the maybe encouragement to have plain language versions of this information have been considered and maybe, I'm assuming, set aside because they were thought to be too difficult. But I'm wondering is there an opportunity to at least include in the comments that encouragement to provide plain language information, especially for those systems that are much further down the road and already doing many of these things.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, this is Leslie and I can comment on that; there were some significant discussions in other meetings. So in general the practice is to provide access to the true record as it's created because interpretation of that true record can lead to sometimes misinformation. But instead to provide access to education materials that are in plain language attached to the record is something we talked about in our response to the interoperability roadmap, to have access to education attached and associated so that every time there is a digital touch, it's informed by the patient. But there was significant discussion in, and I'm sorry, I can't remember which meetings it was, but about this because you do not want to reinterpret the record and you want to be able to attach supporting information.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Yeah, and that makes sense. I guess because in the patient specific education materials I didn't see anything...I mean, I guess you could interpret patient specific might include the need for plain language, but if that's going to be sort of the norm rather than something that's determined patient by patient, I just didn't see that in the language here for patient specific education materials.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

In patient specific...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So Cynthia, let me just clari...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...the term today in the patient specific education materials under the standard does include things like knowing the chief complaint, the problem list and all of that, does include knowing the patient's language. So there are some things in the information that allows it and then there are certification requirements being discussed, not in place yet, for some tools so that there is that idea of plain language, but, we're getting it.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so...

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

Yeah, I think...because clinicians tend to want to, you know, discern and label people who are low literacy because they think it's really just a very small number of people anyway, they don't really want to kind of deal with a broader understanding of health literacy; that's where I get a little bit concerned that it starts to become kind of a labeling and stigma issue.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So let me pause, this is Christine. So you're really talking about the patient specific education materials as opposed to how we let patients know that there is a function, whether it's portal or an App, available to them to view their health information, download it, transmit it; am I right?

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

I mean I guess that's kind of the practical way, so when I think about the portals...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

...that I've used, so I look at the lab results and there might be a hotlink or something that says, click here for information about what this test was or what these results mean and then I click through to something that's equally technical and unintelligible. And so I guess if that's considered the patient specific education material, then yes, my attention is focused on that. I'm not really sure sort of what that is considered within peoples different portals; but that's how I've seen it manifested so far.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, I can work with that in terms of, I mean, assuming there's no disagreement in the group, I can turn that into a comment.

Cynthia Baur, PhD – Senior Advisor, Health Literacy, Office of Communications – Centers for Disease Control and Prevention

I'd be happy to help with that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Great and you guys will see the comments before we do anything with them. So what I'm hearing right now is there is support for making the information available within 24 hours and that that would happen for at least 80% of patients. We assume that the threshold change is more tied to that than the availability, so we would state that. And that we want to essentially say, look it's not that the function is simply turned on, it needs to be used by both parties and then we would also talk about...and I think that will lead us into objective 6, which is the use piece of this.

So what matters is not...so...and then the final thing that I'm hearing is how we encourage plain language in the sort of environment of the health information, electronic health information, which could be patient specific education materials or presentation of the health record and the minimum data set or click through to things that help in plain language, interpret what's there. Am I missing anything or is there any disagreement with that so far? Okay. So, are you guys ready to turn to the API discussion then? Okay, good, I'm going to assume that as a yes.

Okay, so there are a couple of things. We have some experts on the phone; I want to really be sure that we understand the proposal and the technology. I know we had a briefing on open APIs, but I think as a practical matter, we kind of have a lot of...or at least I have a lot of questions about it. We also have a slide that the National Partnership did, which Erin supplied to us after the meeting materials went out, and I think it's really helpful. It's in your email and it's a comparison slide of VDT and APIs, okay.

So, what it basically says is that some of the advantages of view, download, transmit is there is an ongoing established connection to the EHR. There are a lot of functionalities that are common to this kind of portal functionalities, secure message, online appointment scheduling, medication refills, all of those things. There are some down sides, and I'm going to ask the expert that we have on the phone to weigh in and tell us where we're right or where we're wrong here.

So the downside to VDT is its tethered often to a provider's practice, and we've talked about the problem of portal proliferation, so I might have 4 portals, 4 passwords and I'm struggling to kind of bring all the data together. There are some usability issues sometimes and then there's a cost to the provider certainly for the portal and we're starting to see cost charged to patients, like a monthly subscriber fee, which, you know, the more functionality you want, the more you have to pay, which I'm mortified by, but we'll get to that later.

So on the API side, the...it's not tethered to the provider's EHR necessarily although the provider, I'm wondering if it's possible that there would be multiple APIs that could be ONC certified so that Bill, in effect, you would have some Apps not really able to share with other Apps and you might have a proliferation of Apps instead of a proliferation of portals. That's one of my questions. But on the plus side, you know, Apps typically can be developed for different communities of users that have different needs and preferences; I think a lot about disability status or other languages, things like that.

So, we also have a real issue with the application market not being governed by the framework that governs the portal market, which is the case when a portal is offered by a covered entity, and that's HIPAA. So we have some enforcement mechanisms through the SEC, but there's not what I would describe as a strong privacy framework for Apps, particularly when I've got one that's holding all of my health information from lots of different sources. There's a question about whether, if a provider decides not to implement a portal, could you...would you lose functionality, like secure messaging? Or is that part of the App, I don't know?

And then whether there...again, there could be a cost to patients and potentially to providers, for example for downloading the App. There is certainly a cost in the sense of if you're using your smartphone or your tablet and you're downloading over your, not Wi-Fi but the phone, then you're going to have...you could potentially have data charges. I don't know about people who don't have Apps or smartphones or...I mean, sorry, who don't have tablets or smartphones, if you just have like a regular library computer, you are not going to be able to use this, but you could log on to a portal. So, hopefully that...we have some experts who can clarify and talk about some of these issues; Chitra...

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

Yeah.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...who do you want to...okay, great, who's that.

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

It's Phil. So...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Oh, hi Phil.

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

...I guess a resounding yes. So, oh, was I not one of the...okay, I may not have been one of the experts you're referring to.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

No, you're not, but I do want to hear from you, but...

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

Oh, how awkward.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Let me...let's figure out who are our experts on the...who are available to us. So Phil is one, who else do we have on the phone from the federal side?

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation - Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Hi, this is Maya Uppaluru on the Innovation team at ONC.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Sorry, hi Maya.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Hi.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Who else?

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

This is Julie...

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

Dan, are you...sorry.

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

This is Michelle; I think Dan is on the public line, so we're just moving him over.

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

Okay,

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

Sorry about that.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And which...can you talk...Dan, first name, last name, what he does so that folks know.

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

Chitra, do you want to talk about Dan?

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

Dan, are you on the line?

Daniel Chaput – Office of the National Coordinator for Health Information Technology

Hi, yes.

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

Dan's on the line.

Daniel Chaput – Public Health Analyst - Office of the National Coordinator for Health Information Technology

Dan is here, Dan Chaput from ONC; I'm a public health policy analyst and also have about 30 years in IT.

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

This is Ju...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great, thank you, Dan. Anybody else? Okay, anybody else on...sorry.

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Sorry. Hi Christine, this Julie Chua from OCPO, ONC.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And what's OCPO?

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

The Office of the...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

The Chief Privacy Officer...

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

...right, yes.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, got it.

Rose-Marie Nsahlai – Office of the Chief Privacy Officer - Office of the National Coordinator for Health Information Technology

And Rose-Marie Nsahlai is with OCPO as well, the security and privacy division of ONC.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great. Anybody else, including workgroup members who are kind of an expert in this area?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, got some of the background on these and be happy to help...called upon.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, great. All right, so I'm going to ask Chitra, who should we start with to kind of talk...speak to maybe the slides we sent out or whatever, that will help us understand some of the pros and cons of each...

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

Either Maya or Dan; Maya, do you want to go?

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Sure, I just want to clarify about; I guess maybe...this is a question for you about our role. I think we're not really here to opine, right, on whether or not...is our role kind of to say, you've correctly identified these five cons or just to kind of comment on the technical...any technical questions you might have about how something would work?

Multiple Speakers

(Indiscernible)

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

It's the technical quest...sorry.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well no, I think it's both, Chitra. I think it's really...do we have it right that for example, you know, is it possible that we will have a scenario where provider A has selected two or three applications that are different from provider B and therefore I just now have two different Apps instead of two different portals? Like, you know, so it's those kinds of questions...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...that's where I think we need some help.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right. Chitra, from your perspective, do you think it's okay for us to kind of talk about, you know, whether or not we think that's a true concern or...

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

Yeah, you can talk about what...yeah.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

I just want to be sure that we're not overstepping our bounds. I think that is a...from my perspective...this is Maya; I do think that that is potentially concerning. I think it's one of the things that CMS is requesting comment on, so when you look at the rule, you know, the next part kind of says like what are some of the additional things that we should be keeping in mind in terms of allowing the functionality. I think that the multiple App issue...I think there's an issue around like does the patient choose the App or does the provider choose the App.

If you look at the work that Project Argonaut is doing right now, they have four test use cases that they are kind of structuring their framework around, they're public; you can find them online. Two of them contemplate data being sent to the user, the patient, but they are contemplating physician prescribed Apps; so the physician would be recommending the App to their patient. So I think it's an open question as to who is choosing the App that would be...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yup.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

...taking advantage of the open API to some extent. Dan or anyone else, did you want to opine on that?

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Sure, I agree it's important to understand that the API is just a...is really another software application uses the API, so an API is never used directly by a consumer...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

...so it's always through another App.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Now that...the A...it does not necessarily limit it to something on a smartphone, it could be a desktop computer could use an API and that's the way software is written today, so in fact a portal, an EHR's portal could use the same API that another independent App could use. It is just a way of; in this case, this API is used to get at the EHR's data, so it's an independent piece.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right, right and I think I would also kind of highlight, you've mentioned...cost to patients and to providers, I think there's also a cost here to potential mobile Apps that would want to utilize an electronic health record vendor's API that maybe hasn't quite been identified here. But, for example, if your vendor has an Open API Program, in order to become an...registered, there's like a registration process that the startup or the App company would have to go through, and there may be some cost associated with that as well. So, it's another kind of thing to keep in mind, because I noted here that you have mentioned cost. So that might not necessarily be something that the patient pays, but it may be something that affects the marketed Apps from which the patient could choose.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Well, but I guess my question on that is, this is not just any random API, this is an ONC certified API; is there a cost to that certification process that's going to be basically built in and passed down to consumers?

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

I mean, there's a cost to our current certification process so I would imagine the answer is yes; but, I can take that question back and get some more clarity on that for you. But I mean, to go through our certification process today with any of the independent certification bodies, there is a cost associated with that, you're right. So, probably yes.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Right, because in this case the API right now is part of the EHR.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

It's something in the EHR that exposes data into the EHR, the App...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

It wouldn't necessarily be like a separate thing, I guess unless somebody only wanted to...like a modular certification, only to have an API, but I'm not really sure how that would work, right Dan?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie; wouldn't that be highly optimal to have a modular certification for any Apps that want to be certified against the API only? That would reduce the cost and would also make it very consumer-friendly for applications to enter the market.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right, but we're talking about...I'm trying to think through some of this. I'm trying to think of what that company would be, because the whole point of having the API is you're the data holder, right? So we're talking really about the big EHR companies. Unless you were a company that offered just that functionality and you were a company that integrates, you know, with EPIC and Cerner and all of the vendors...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

...to provide an API.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

For instance, in the interoperability showcase at HIMSS this week we saw a company that was just offering...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Yeah, yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...some very specific thing that would be certified inside the Cerner App Store, or certified inside the EPIC App Store but they'd be providing a very narrow functionality, we want to encourage that.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right. Yeah. So I think though...that I want to take back and clarify, but I think that's correct, if you...do that, because you can modularly certify right now for VDT, so, I would...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So but Maya, I think isn't the part...I just want to make sure I'm understanding, it's Christine; is part of the...so, who's going to get certified is number one, the E...the big EHR or any EHR company that's going to basically say, look, you can either offer a portal or an App. But the EHR company has to include that in its certification for this to work because they're just talking about the API, right? But then, which I think as Dan just said, exposes the EHRs data. But then, you would also need to have an application that uses that same API, right? So...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

(Indiscernible)

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...somebody like, did they have to get certified or are they just...or does the EHR company make its API publically available, how does it work for the little teeny mom and pop shop?

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right. So I don't think that the App would have to be certified by ONC. So there are a couple of different certification or registration practices that we're talking about here; one's the API that's ONC certified would be an API that the vendor offers, because that's the data, right, that's coming out? And then the App that gets to take advantage of that open API and that data that App wouldn't necessarily have to be certified by ONC. Does that make sense? Because the API, like that thing that they're exposing, that's what's being certified. Now...

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

Yeah that does make sense.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

EHR companies...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Sorry, can I ju...having said that, the like EPIC or Cerner of each individual vendor may have their own registration process that they require Apps to go through before they can access the API, that's not necessarily the same thing. Does that make sense?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

...I'm sorry, you were about to say something?

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

Yeah, hey, this is Phil, I was just sort of validating or you know, supporting what you said about the App not needing the certification. I wanted to...is it okay for me to make a comment?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, please.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Yes please.

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

Okay, so chomping at the bit out here. So first of all, the API approach opens up a whole opportunity for consumers to be able to leverage their data; I think we recognize that, it's hugely, hugely important. But, whenever I hear things like, physician prescribed or EHR system provided and approved, EHR marketplace, etcetera, etcetera, somebody else is choosing, right? The consumer's...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Right.

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

...ultimately going to choose, but it's the provider or the EHR company that's choosing because they know best. And the truth is the API is just another, and frankly easier, mechanism for VDT capabilities. And when a patient has the ability to go into a portal, with a user name and password, in order to conduct a VDT transaction, the API really has to be just as freely available for the patient, for the application they choose. And so I would say that if we're going to be on the side of consumers, we need to make this as easily accessible as going in and conducting a VDT transaction. In other words, if a patient has the credentials necessary for their portal, and they can put that into an App, I don't care if its mobile or its web-based or whatever, that they should then be given access to their data through the API and it's their choice. At that point, I mean, you know, I'm not a HIPAA uber-expert, but I know, I think this much and that is, what patient has chosen to take their data now it's free and clear of that HIPAA constraint, because after all, it's their data and they should be able to do with it what they want. So I would...so first of all, just completely support everything we're talking about here, but then just verify that this is simply a better, easier, more efficient way for patients using whatever they choose to be able to access this data through this electronic interface that's been certified on the EHR side yes, but not constrained otherwise. Does that make sense?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yeah, it's Christine. That actually leads me to like a really important question that is...that I think underpinning what Phil is commenting, which is, I...I've been on the Policy Committee since we started 6 years ago and I had been on the Meaningful Use Workgroup the entire time. When we recommended the view, download, transmit functionality, it was based on Blue Button; this was exactly what we had in mind.

So I thought, and tell me where I'm wrong, that today under Stage 2, not waiting until Stage 3, that a consumer could go into their portal and download from these different portals that they may have or from their local hospital and put it into an App, which would require the right kind of API, I suppose. But how is this proposal different than what we...what I think we should have in Stage 2 today? Dan or Maya, can you guys help us with that? I mean, you're supposed to be able to download.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and the difference is that today's construct is mostly around a document, that you can view it, download it or you can ask that document to be transmitted. So as a transaction it's a document request. In the open API, what we're getting at more is what we talked about, and I think Christine you coined the term, the set and forget function. I want to assign an App that it knows when there's a quer...when something changes in my record, that App is updated. That's one application. So the Blue Button Plus that's been talked about is really around using the API approach.

So it's very different in the...how the open API constructs itself in that it's now not just an individual document request, it's multiple Apps working together in a common API that allows people to have things automatically processed and sent for, I might have a consent App that I work with and I might have an education App, I might have my Fitbit App underneath the Cerner API functionality. So those are all sort of components that the patient can control and assign for interoperability versus today's construct is more around a document request be able to view, download or transmit. Does that make sense?

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

Leslie, this is Erin. Sorry, it does make sense but I'm really confused by this...I mean, can the vendors I guess who are developing these APIs which are then going to be certified by ONC, can the vendors discriminate to who may publish those APIs? Because to Christine's point about App proliferation, the way it's been described if my doc, my primary care physician recommends one App and my allergist recommends another App, but I really like my allergist's App and I want to use that to consolidate all of my information, the allergist's API vendor doesn't necessarily have to choose to interact with my PCPs EHR under the way I think it's been described, which makes me feel like this isn't...doesn't...I mean, if it plays out that way, that's not much better for consumers than what we currently have or...correct me.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Yeah, I think that's correct, you've correctly identified what I was...talking about...this is Maya again, sorry; what I was talking about before with the registration requirement. So one of the...in the proposed 2015 ONC certification, right, we're moving away to the 2015 cert, there are three requirements that the API must meet in order to get certified.

One of them is a security requirement, so it would be on the vendor then, or whoever is getting certified, to assure that there is a means for establishment of a trusted connection between the App that's requesting patient data and the certified entity, whatever that company is. So that would mean a means to register with the data source. Does that make sense? So I think we could talk about it in different ways, but...and the word discriminate has some negative connotations, right, but there's also a quality control issue and a privacy and security issue that would make sense for a registration process. However, you're right, like let's say that there is an App that hasn't been through the registration process with my particular EHR, but my pharmacist has said I should use it, you know, then that is a potential issue.

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

Well...pretty clear...

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

This is Nick.

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

It's Phil, sorry. Just to be clear so I understand what you said, so first of all, the certification criteria of the EHR to make the API available makes total sense; of course you have to register as a patient to have those credentials. But...

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

I'm sorry; I just want to...that. The application is registering, not the patient. So to Dan's point earlier, like we said, the patient is not going to do anything with the API. If I'm a patient sitting in my home, I have an App on my phone that App is going to do something with the API, not me the...

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Yeah, sorry. The patient would have some sort of a credential, let's to make it simple, an ID and password, in the EHR that they would then use with another application to access their primary data store in the EHR through the API. So, it's that credential that the third party App, let's say your App is developed by a third party, you say oh, go to my doctor's website at this address and use this password and ID and set up a secure connection and get my data with that, so you...

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

Right.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

...the individual user would be required to configure the connection.

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

Yeah, that's exactly as I understood it as well and that's fantastic and just for the workgroup's benefit, you know how I interpret that is I as a patient have my choice of applications, right? I don't need to certify that application, I have the proper credentials to go through that pipe and snag my data and I would say that really at that point, from a consumer's standpoint and our advocacy for them, that as long as we push for minimal capabilities through that API that can support consumers, that that is a great way to go without really putting any undue encumbrances upon the application environment. So that's sort of how I interpret that.

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

So this is Nick, I had a comment on the privacy security piece. I take the point completely that whether you're using an App or an existing browser or something under either of these technologies, the patient should be able to get their document. And to an extent, then the patient is responsible for the care of what they download. The complication when you're using an API and you're using Apps is that the patient is not the only player at that point. There is the App developer and whatever else the App developer is trying to do with data that's flowing through the App or through the interface that the developer is building to the API, some of which goes to the patient. HIPAA does not...HIPAA privacy and security does not apply to anything that that developer may be doing.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right.

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

So it's out of the consumer's control.

W

Right.

Maya Uppaluru, JD – Policy Analyst for Health Innovation, Division of Science & Innovation – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Yeah, unless that App happens to have some kind of business associate agreement with a covered entity...so there is a potential for that, right? But yes, other than that, yes.

M

That's right.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

And those are good...those would be good comments to make.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And this is just Leslie, the way that this is manifesting itself is that if you become compliant for one EHR, you're compliant for the other EHRs; these things are...API is really unleashing tremendous opportunity for the consumer. Where I think it is very important is that the patient has the ability, based on their relationship with a provider who knows who they are, has identity proofed them, you've given them their...you're insuran...given them your driver's license; then that App is able to register you and then you can then elect where your data moves and what application or App you choose. So, I think this is all really incredibly positive, incredibly powerful when for the first time by this construct we have the ability as patients to actually control where our data moves and how it moves.

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

This is Nick again and I don't want to put a dark cloud over this and always be shouting HIPAA, no HIPAA. I agree it's extremely exciting; it's also possible that we will see markets operating so as to favor Apps and App developers who provide better security and privacy, which is a great market to lever.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, it's Christine; let me ask some of the folks from the Chief Privacy Officer's office to weigh in here, Julie and Rose-Marie, do you guys want to...can you tell us what constructs govern Apps that hold consumer data, FTC, blah, blah, blah?

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

This is Rose-Marie, FTC has...regulates a selected number of Apps and the regulation doesn't extend to any Apps owned or controlled by the consumer. There is a list that was published by the FTC a few months ago which details when an App is under regulation or not; however, most Apps are not under regulation by the FTC.

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

Excuse me for interrupting you, this is Nick. Do you mean FTC or do you mean FDA?

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

The FTC.

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

What document is this?

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

So the FDA does not regulate anything having to do with privacy, so what Rose-Marie is saying is when it comes to privacy, it's the FTC that you're looking to.

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

I understand that, but she referenced a document which laid out which Apps were to be regulated or not; I'm not familiar with that.

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay, I will pull it up and try to...we discussed this during an FHA meeting, so they did list criteria for when Apps are regulated and when they are not if they are owned by the consumers. And they had a disclaimer stating that it wasn't a complete list; however, that was a little bit of guidance to the consumer and the App developing community to have a base level of understanding. So I will pull it up and see if I can send it to Michelle right away.

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

Hey Christine, this is Phil. So this is really such an important topic and I think that our input here is incredibly powerful and...important. So I want to make sure that we're heading towards something that's going to be really, really important and it sounds to me like the APIs that are going to be required of the EHR vendors are going to be required to have...you know, be certified, which is awesome, and the patient's will have credentials that will allow access to their data using the API and that's awesome. And then at that point, really for consumers to know that they can get some level of functionality out of it; is there a baseline set of API functions that we should be pushing for?

For example, I assume the CDA document will absolutely be part of this, because it's part of the VDT requirement anyway, but there are other API calls, basically endpoints if you will, that consumers would benefit from. For example, having an automated update to your chosen App after an encounter is one of them, for example. And so I'm just wondering, this is a great direction and I'm just wondering how can we push for a baseline that's really going to be quite compelling?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So let me...so, I have that...I want to put that on the placeholder list for a second...because I want to come back to the security piece for a second, because I'm not sure I understand what we just said. But, I have a list...I have a question that's the same as what you're asking. So if you don't mind that we could come back to that in a few minutes?

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

Yeah, of course.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. So I want to com...so, I got...Nick, you will help me on this, I know you will as I'm sure the CPO folks will, too. So I guess what...the question I was trying to ask about FTC regulation, I'm probably not asking it correctly. I'm really trying to figure out what legal framework governs the data that sits in an App, whether that App lives on a website or on my smartphone, you know, I'm not as focused on here, but when we talk about false advertising and things like that, right? What are those...that's the framework I'm trying to understand; it's not HIPAA, so it's something else, what are the something else's so that we as a group really have a stronger sense about the potential risks in this space for consumers if they don't either read the privacy notices carefully or, you know, whatever?

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

Okay, so this is Nick and let me take a first stab and then you can chime in. Essentially once that data has left...has been channeled through the API and is now sitting on the consumer App, that essentially is unprotected space; there is no general protection for that information in that state at that time. The slight modification to that is, if the App vendor, seller, whatever has put a privacy policy in with the App, then if the vendor, developer, etcetera, failed to comply with the privacy policy that they state, that is arguably an unfair trade practice, a misleading practice and the FTC has shown its willingness to get involved in such things.

Beyond that, there is relatively little regulation of that space. There is a key case going through at the moment from the...with the FTC called the Wyndham Hotel's case, which is about security. If the FTC wins that case, they will be able to interpret their remit a little more broadly than what I gave you. But at the moment, what the HIPAA-free zone means is, there's almost no regulation and in fact, arguably the consumer at the moment gets more protection from the rules of the App stores than they do from government.

So for example the Apple Store has developer guidelines that require a privacy policy and prohibit the use of health information for advertising. You also have to drop an extra footnote here for those of you who got up early because you're on the West Coast, for example if you live in California, the California State Health Privacy Act does apply to Apps. That's the end of my first lecture.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

That was great, condensed lecture, Nick, thank you. Any comments from the Chief Privacy Officer folks?

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

No, I think what he stated is extremely correct; that once a consumer retrieves his or her information, it's no longer governed by HIPAA and that's a consumer mediated exchange, which is happening right now with...the Blue Button movement...Blue Button movement for consumers. And the FTC is involved in some of the regulations right now, fining for protection against child information, children health information through Apps or information that has to do with melanoma. So there is a lot of literature on the Internet that has to do with FTCs input with regulated Apps, when they go above and beyond what they're supposed to do and offer advice. But that is still an open space, nothing is final yet; it's still a work in progress by the FTC.

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

Again this is Nick, let me be clear. The offering advice piece is not FTC, it is in the FDA guidance on mobile Apps that came out first in September 2013 and was just renewed last month.

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Could I ask a question? This is Leslie. I think that this hits on a point, what does it look like when a patient downloads information with regard to privacy and security, the data segmentation or we heard early on, computable consent and that...so there's an opportunity for the patient to understand what they're bringing down, what information they're being shared with, what kind of consents they might use. Is there an opportunity to learn more about this or is timing such that this is our only opportunity?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Do the ONC folks want to speak to that?

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Sorry, this is Julie Chua; I just wanted to clarify, I was on mute. I wanted to clarify the question, was the question with regards to giving a briefing or giving an overview of the topics you mentioned to this workgroup so that you can integrate that information into your comments for the NPRM?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Or was it that...yes, so that's the question. I'm not sure, Michelle, in terms of timing if that is something that is feasible for the work plan for the Consumer Workgroup, to have like a session on...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Do you guys have written resources that you could provide or a slide deck or something that sort of outlines it; because we may not have time for a briefing, but we do need to consider some of these issues?

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Umm...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah I think that...maybe Debbie from the ONC, I can't remember her last name, and I think it begins with a "B."

W

Bucci.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah. And Mike...is that correct from the VA?

W

Mike Davis.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Why don't we do this, why don't you send me or Chitra a note, here's what, you know, to give us an outline of what you're thinking, what the questions are...

W

Okay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

...and then let us work offline to figure out how to get the information back.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That would be great.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, cool. So, okay, so I want to do a little bit of a time check; it's 12:15, so what I think is reasonable for today is going to be try to get all of our questions about APIs asked, because I'm thinking...or rather asked and hopefully answered, because I think on...what we're going to need to do on the next call is that there are a whole bunch of alternatives to the proposed measure 1, this whole VDT or API could be VDT and API, so there's alternate, A, B, C...that's a couple of slides forward from where we are. So I want to get us really ready to have that discussion, if that makes sense to folks.

So, let's talk about...I want to come back to Phil's question first and then have you guys, have your remaining questions ready. So Phil's question is a good one, which is, should we be thinking about, you know, well, you can only use an API if the application that's using the API also offers these functionalities? Is that right, Phil; is that the right formulation of your question, first?

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

I'm not sure that it is.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Oh.

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

So, what I was saying is that, remember, you know, as I understand the process, one of our only levers here is what the Meaningful Use criteria are going to be and so from the API perspective in Stage 3, there are going to be certain requirements and so of course, it has to be certified, it has to be secure. If the patient has their credentials, then they can access data through the API. Well APIs are composed of functions. There may be, for example, what's called an endpoint, an API endpoint that's called retrieve C-CDA. Okay, so you go and you get your full health record summary using the C-CDA document format, there may be also one that says, pull any data that arose as a result of an encounter; so basically an incremental update, what's changed in the EHR. So that may be an API endpoint as well.

If you look at the API documentation of EPIC or Greenway or Allscripts or any of the others, and by the way, they all build their marketplaces on their own proprietary API infrastructure. You'll notice that they have a whole library of different calls and different functions that they support and so my...as the Consumer Workgroup, I think this is a great opportunity for us to actually push for certain baseline API functionality that the EHR systems under Meaningful Use will be required to have. That's what I was talking about is what API calls are available, and I do think that there's an opportunity to push for a certain minimum number and perhaps, I haven't read all the documentation here on the proposed regs, but perhaps there's some of that already in there.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So this is Leslie; an example might be then that you're talking about, for instance, patient matching so we know that if a patient is using, the example given earlier from their dermatologist, one App function and from their primary care another App function, that they know...those functions know the same patient, they're...

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

Actually, that one wouldn't be in there and here's why.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

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

Because remember part of the baseline requirement was that the patient has their credentials to go and grab their data and so, you know, if I can go and grab my data using those credentials, there's really no matching process that would be necessary, nor do you even really want that to be there. I'm thinking about in addition to the whole record summary retrieval function; you've got sort of the post-encounter update function. You've got maybe a subset of functions like, I want to pull my problem list, I want to pull my med list, I want to pull my lab results; you know, maybe those are sub-functions. And I'm just wondering, and I've got a sense myself for what consumers are going to find most valuable to utilize in their Apps.

And by the way, I am assuming that all of this is going to adhere to good structured data standards like the C-CDA with SNOMED codes and all that; so, I think that's important because one thing I saw in the documentation was that this is human readable, and I got to tell you from an API standpoint and from an Apps standpoint, just pulling a set of words, your problem list, your med list in just natural language is practically useless.

M

Yeah.

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

And so I just want to call that out as well. So yeah, I was actually thinking of that other stuff.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So maybe...this is Leslie again; so one thing this group has talked about in the past is advance directives as a minimum requirement so that no matter where a patient was, an advance directive function might be required.

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

Right, good example.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Or...yeah. Those items you mentioned, all the sub-items like labs and meds and such is a great one to do because that's the subset of a CDA, it's available and it's very important for patients to get that specific information.

Multiple Speakers

(Indeterminate)

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So guys, let me...I need to ask a question, it's Christine.

Julie Anne Chua, PMP, CAP, CISSP - Information Security Specialist, Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Sorry, can I just jump in to address what Leslie just said really quickly. That is, actually in the 2015 certification, so there is like a data request response...requirement for the API stuff in 2015 edition and that would allow the API call to be used specifically for medication or for any data category within this EP set, so sorry.

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

Great.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So we...I think we were going to...well, that's part one of my question, actually. I think, Chitra, I thought we were going to review the certification criteria around VDT which would include APIs, I thought you had someone who was going to do that for us and I would expect that maybe there's a slide deck or something that kind of goes through that for us. Am I wrong on that though?

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

So Dan was going to go through the VDT for us, but I guess we don't have time today.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, so Dan, maybe next time you could bring some of that in so that we understand how the policy is translating into the technical.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Will do.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

And I'd be happy to work with you that.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Okay, will do.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Thank you.

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

So Christine, could I...Christine, when that report is given, it might also be useful sort of to talk a little bit about sort of the public APIs and private APIs because one assumes that if I was an EHR manufacturer and I was thinking of making an App for the App Store, I could gain a competitive advantage by restricting the public APIs and tending to...and therefore favoring my App over competitive Apps...

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Right, right.

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

...both of which are accessing the same basic data.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

I totally agree and one of my questions was, I think Maya mentioned the three criteria for certification and she only talked really about the security piece, but should or is another one that it has to be a publically available API, because I am worried about, you know, we've seen vendor practices with EHRs trying to build interfaces to other data sources where you have to pay to build the interface, you have to get the interface certified and then you're actually getting charged by the vendor for the data that flows through that interface, even though it's not coming out of their system at all. I don't want something happening to consumers like that, so, Dan, I don't know if there's anything in the rule that you could speak on that next time, but...and if not, that's okay, but you know, just letting us know that, that would be awesome.

We've only got a few minutes left and I'm going to kind of throw a question out there and then we might have to cut discussion off early in order to do public comment, but I want to see how we should best continue the discussion for next time. So when I'm hearing you guys talk about different functions of...or, I think so maybe you talked about you know, you calling them like sub-functions of APIs, you know, how do we...does it contain an advance directive, blah, blah, blah.

What strikes me is we have always in the Policy Committee tried to be platform agnostic, we've never said you have to implement a patient portal. We have always simply said, you need to give patients access to their health information and this is the data set they need to have and it needs to include labs and a problem list and you need to do secure messaging and blah, blah, blah. But we've always said, we're not going to dictate how that happens; if it happens through an application or you want to use HealthVault, that's fine; as long as you can check off this list. Part of what's happening with this notion of API, does it...I mean, are we going to be...are we sort of basically not being as platform agnostic and is that the right approach?

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

Christine, from my standpoint...it's Phil, I actually think everything I've heard today, and a lot of this was sort of news to me on the API approach by ONC so far, actually is extremely platform agnostic and really provides a baseline of functionality that now really opens up the opportunity for consumers to let...utilize technology in ways that hadn't been possible before. So, from my standpoint, as long as the EHR systems are certified to have basically identical functionality, it just really opens things up in an extremely forum agnostic kind of way, in my opinion.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree; this is Leslie. What it does is puts the burden of the technology at the EHR vendor not at the App, so the vendor to be competitive has to show as many different Apps in their App Store and it's the certification that they're required to meet is what makes it agnostic. So this is our biggest hope, so...

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

And to that point, Christine, I just wanted to throw on one more question which is, I don't...what happens to the functionalities like secure messaging that have previously been facilitated by patient portals? Understand all the potential that APIs have for consumers, but what does that mean specifically for secure messaging. Do...will doctors and vendors have to be both providing patient portals and this new API thing to continue to support secure messaging or are there API enabled ways to securely email your doctors. I have no idea if that's a stupid question.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Correct, Erin, you're...yes, so actually DirectTrust and NATE and others are working on an API-based approach to the secure messaging structure.

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

Okay, thank you. I just don't want to lose that piece; I know that's very important to consumers.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, I'd like to know more about that on the next call, what that...what it means to have an API-based approach to functionality like secure messaging because I think we have to be 1000% certain that we don't lose that piece, if providers were to go the API route. So, is there somebody maybe from ONC or...that could take that on? Dan, I don't know if that's you.

Daniel Chaput – Public Health Analyst – Office of the National Coordinator for Health Information Technology

I will...yeah, either I will do it or I will see it gets done.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Awesome; yup, you're so great. Thank you. All right, so let's go ahead and open the lines for public comment and then we'll kind of come back to our discussion for a second while we give the public a chance to dial in. So could somebody either queue the operator or can the operator open the lines?

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

Lonnie, can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

Christine Bechtel, MA – President – Bechtel Health Advisory Group

So, are there any other questions that we want to make sure get addressed in our meeting next week about APIs? I think the one that I want to make sure somebody is tackling, too is whether or not we're sure that APIs can be...are they act agnostic or not? So if I pick API A, does that limit...or my doctor, rather, picks API A, does that limit me to these three Apps and if my other doctor picks a different API and that limits me to different Apps then how do...in other words, what do we need to do in policy to make it so the consumer is able to say, this is the container that I want to house my data and I can suck it from all the different places that it is. That I feel like I don't quite understand.

Amy Berman, RN – Senior Program Officer – The John A. Hartford Foundation

This is Amy Berman. I also have kind of two questions gnawing away at me; one is related to security and one is related to functionality in an API. The security, I'm just wondering whether there are still HIPAA logs, like if somebody wanted to see the flow of information, as one can do in an electronic health record under VDT, could they still be able to see who is receiving their information and have the ability, should there be a breach, to track where that breach may have gone? So that's one.

And then the other relates to functionality, and I guess this is a bigger question than just the API issue, but I'm just wondering if people are...if there is the ability to synthesize data from multiple sources through an App through the benefit of an API, whether when it comes to the pharmacy issue, the medication list, we don't show orders to discharge, we show new medication list and since lists will be coming from various providers, the question becomes what still is the medication versus what is not. And so I'm just wondering what policy do we need to think about, including a discharge policy, in order for this to be workable, usable and not create additional harm.

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

I had one further thing to quickly add, Christine. How does the provider know that the person with the App is the patient?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. So, okay. I'm going to write these...I'm writing these down and we'll work with Chitra and Dan to get these questions answered. Are there any public comments?

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

No public comment.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay. Okay guys, thank you so much. If we've missed any questions that you want to make sure we've answered; please email Chitra or me and we'll get them in the queue for our next meeting, which is on Tuesday. And we will go from there and we'll try to get through the second half of the slide deck that we have today, and then we'll be able to go after that, we'll jump into objective 6 on our call next Thursday. In the meantime, thank you guys again; so much and I appreciate all of your input and send us any other questions that you have.

Thanks also to all of the ONC folks for joining us today; we really appreciate the support and health and look forward to working with you.

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

...Christine. Thank you.

W

Can you confirm the data of your next call?

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Yes, the next call is April 28, which is next Tuesday, at 12 noon Eastern time and the call right after that is Thursday April 30, and I'm sorry to report Phil, that it is at 9:30 a.m. Eastern time.

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

That's okay.

Christine Bechtel, MA – President – Bechtel Health Advisory Group

Okay, thanks everybody.

Multiple Speakers

Thank you.

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

Thank you.

Public Comment Received During the Meeting

1. We determined a 3 day hold is needed to allow providers to alert pt about results...
2. Can you define what plain language is? Is it based on reading level? What reading level is considered to be plain level?
3. What does the acronym PGHD mean? Slide 3 I think