

Health IT Joint Committee Collaboration

A Joint Policy and Standards Public Advisory Body on Health Information Technology
to the National Coordinator for Health IT



Joint Health IT Policy and Standards Committee Application Program Interface Task Force Final Transcript February 9, 2016

Presentation

Operator

All lines are now bridged with the public.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – 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 Joint meeting between the Health IT Policy and Health IT Standards Committee's API Task Force. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Meg Marshall?

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Here.

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

Hi, Meg. Josh Mandel?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I'm here, hello.

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

Hi, Josh. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I'm here.

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

Hi, Leslie. Rajiv Kumar?

Rajiv B. Kumar, MD – Clinical Assistant Professor of Pediatric Endocrinology & Diabetes – Stanford University School of Medicine

Here, good morning.

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

Good morning. Aaron Seib? Drew Schiller? Richard Loomis?

Richard Loomis, MD, CPC – Senior Medical Director & Informatics Physician – Practice Fusion

Hi, good morning.

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

Good morning. David Yak?

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Yes, I'm here.

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

Good morning. Aaron Miri?

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

I'm here, good morning.

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

Hi, Aaron. Robert Jarrin? Ivor Horn? And Linda Sanches?

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Department of Health & Human Services

Hello.

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

Hi, Linda. And from ONC we have Jeremy and Rose-Marie on the line, is there anyone else from ONC on the line? Okay, with that I'll turn it over to you Meg and Josh.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Great, thanks Michelle, so we've got a pretty packed agenda today lots of things to talk through. Our first meeting back after the hearings from last week. So, just real quickly wanted to say that I thought the hearings last week were fantastic. We really got a lot of information, a lot that needed to be synthesized, a lot of key themes and we're trying to figure out how to guide the discussion in a way that will help facilitate the final recommendations that we send back.

So, one of the things that we're going to do, and let me just walk through the slides, okay, so on slide two just as a recap of the hearings, we heard from panelists from across both non-healthcare and healthcare industries. We did receive written testimony from the panelists and we also received public comments, written public comments as well so they have all been gathered. And then we've had quite a bit of analysis started so far to try to summarize those themes to move forward.

Slide three, the virtual hearing panelists, we heard from five different panels over two different days, two panels from consumer technology, we heard from healthcare delivery, health IT vendors and consumer advocates.

And a refresher, on slide four, around our Task Force charging questions and I think as we approach APIs and this whole world of things that can potentially happen to support facilitating APIs there are a lot of things that could potentially come within the boundaries of our discussion and so just...I think this will be valuable to refresh, again, against our charge and the questions that were posed to us as the Task Force was created.

So, we're looking at three different things identifying perceived security concerns and real security risks that are barriers to the wide-spread adoption of open APIs in healthcare and in particular around that for risks identified as real, identify those that are not already planned to be addressed in the interoperability roadmap.

And I think that we're going to find, you know, that as we go through and we are remembering the discussions and trying to pull out our recommendations that I'd like to approach this from, and Josh and I have talked about this, sort of an unfettered type of discussion and as we go through and pull out what the final recommendations are going to be what we may find is we may find that we do have a recommendation that was already covered in the roadmap itself, but, I think that it's much better to start out broad and then try to narrow it as we move forward.

So, the second one of that is the privacy concerns identifying privacy concerns and real privacy risks that are barriers to the wide-spread adoption of APIs in healthcare. Also there is some consideration around those things that have already been planned to be addressed in the interoperability roadmap.

And then finally, identifying priority recommendations for ONC that will help consumers leverage API technology to access patient data while still ensuring the appropriate level of privacy and security protections.

So, that third bucket I think allows us a little bit more creativity as far as what we think could be something that would either be an opportunity or a barrier as far as consumers leveraging API technology.

So, again, just as a quick refresher to walk through, the health IT certification criteria specific to the API access for the 2015 edition criteria ONC established a requirement that health IT should demonstrate it can provide a consumer-facing application access to the common clinical dataset via an application programming interface.

So, at this time the certification criteria does require read only API and it is split into three separate CEHRT criteria with each individual focusing on specific functionality to enable modularity and flexibility and those three are patient selection, data category request and all data request.

On the next slide, to be certified for the API criteria three privacy and security criterion must be met the first one being authentication, access control and authorization. The second being, trusted connection and the third being auditing actions on health information or auditable events and tamper resistance.

And on the next slide, slide seven, so we do have some guidance around third-party application registration in that ONC indicated, in a toolmaking, that the intention is to encourage dynamic registration and that they strongly believe that registration should not be used as a means to block information sharing via APIs and the citation is of course on that slide if you wanted to go back through and read the entire text, but the thought is that dynamic registration...the application should not be required to pre-register or be approved in advance with a provider or their health IT module developer before being allowed access to the API.

And then they note that this is supported by the CMS Meaningful Use Stage 3 Final Rule that providers may not prohibit patients from using any application including third-party applications which meet the technical specs of the API, including the security requirements.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Hi, can I ask a question?

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Yes.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Hi, this is David Yak. I don't see the term identity proofing being called out specifically in the slides and frankly I haven't read all of the standards or the requirements to know whether that's the case, but is identity proofing considered within the scope of authorization or registration? Because knowing that someone is who they say they are seems to me to be a really critical aspect of security and privacy.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, this is Josh, let me comment briefly and then see if others want to weigh in here. When it comes to identity proofing, just to be clear, this is a property of how a user conveys to another entity, typically how a user conveys to a healthcare provider organization who they are and so that way when a user signs into authenticate to that system the system actually has some way to tie that user's identity back to their real world identity.

And so when we're talking about registration we have to be very careful to separate whether we're talking about the way a user registers like the way a patient would register with an on-line portal so they could access their data and that's different from how an App registers in the OAuth sense where an application developer would register an App with a healthcare provider to whom the App would later try to connect.

So, I just want to be careful to separate out those different kinds of registration and say that identity proofing is really important for user registration. And that said, yes, we do get into it in the themes that we've pulled out here. We talk about the challenges of verifying and authenticating user identity which we'll get into when we talk about themes but there is a slide labeled identity and access management which is where that comes up.

You're right that the phrase "identity proofing" per se doesn't show up there but that's where that theme is addressed.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Other thoughts...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I have another...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Or comments on that?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie; I have a question, tell me what dynamic registration means, please?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yes, and I'm hesitating because I wonder whether we should talk...well, never mind this is a great place to talk about it because it's on the slide, good. So, dynamic registration has to do with that latter category I was talking about. It's not the way that a patient signs up to access the portal, its a way that an App developer registers their App with a provider system.

And in general this is a term from the OAuth world where in OAuth an application needs to be registered before it can get authorized to access data on a patient's behalf. So, typically the registration step happens up front and then after the App is registered and the App can ask a user for permission and if the user, in this case a patient, says "yes, I want to share my data with you" only then does the App get access to the data.

So, registration is a prerequisite that needs to happen before the user is even given the option to approve the App. So, dynamic registration is a specification that says "yes, registration is important" it

needs to happen before the user can approve an App, but let's provide an automated way to do that registration step so we don't have to have, you know, a developer signing into a web portal or making a phone call and waiting three weeks while an administrator thinks about whether to approve the App and then makes the approval decision.

Dynamic registration is a way to automate that process and there can be various kinds of policy checks in place to automate the "yes" or "no" decision but in general dynamic registration as ONC has endorsed here in this comment is to say, the process of registering an App should not be the barrier to opening up the data, a patient's approval should be the barrier and that's sort of the one and only and most important place where a decision gets made not about whether to let the App even register to ask for access in the first place. Does that make sense? '

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, I really appreciate you doing that. Thank you.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Sure.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Josh, do they define third-party applications clearly in the documents you've read?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Well, I think one of the best places that we can look is in ONC's commentary on the certification criteria themselves the way they talk about the idea of encouraging dynamic registration.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Okay.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

And so what ONC says in that commentary is...let me see if I can sort of cite chapter and verse here, so I'm reading through right now the ONC's commentary in the certification rule. They say "the App shouldn't be required to preregister."

And the idea is the user can view the patient's data when the application connects through a connected source. We talked about diverse and innovative applications that make it easy to discover what data exists for a patient.

But, I don't think we have, at least in the materials I've seen, I don't have like a pithy definition of what a consumer App is...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Okay.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Other than something that a patient would choose.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Interesting, okay, thank you, something that a patient would choose, got it.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

And this is Aaron Miri, so I'd just...Josh I want to just clarify what your last comment was, so something a patient may choose but not something an application may choose on the patient's behalf, correct? Because those are two different concepts.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Well, let me back up, the question that I heard was what is an App? What is a consumer App or a provider-facing App? And so the App...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

A third-party...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

The App couldn't choose itself.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

No, but I could see many brokerage...anyway I don't want to go down a what if, but I see your point. So, you're talking about a conscious decision that patient...I'm a patient, I want this App to grab my health data from this EMR, it should technically be allowed at my will.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, that's exactly the paradigm that was...

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Yeah, that scenario, got it, all right.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Hi, this is David Yak, could I maybe try to clarify one thing, the question of what is a third-party App, I mean, typically the first-party is the patient, the second party is the provider and then the third-party would be someone other than those two who is providing an application for use to access information. I don't know if that helps. I mean, that's a standard definition, I would hope that that's what we're calling a third-party application.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

So, just in that example, the provider has an EMR, that EMR has a third-party App that can access their data, that would be considered a third-party App, if the consumer choose to use that third-party App offered by their provider's EMR.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, this is Josh, let me sort of comment on that part. So, the third-party App would be anything that wasn't developed by the...or provided by the healthcare provider or the patient. So, some other company built this thing and so from my perspective a true third-party App is one that was sort of select...developed outside of the EHR world by someone else.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Yes.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

It is certainly possible that a healthcare provider might package up a third-party App and offer it to the patient as part of their care and then I think we get into sort of a gray area because then you say "well, is this really just part of what the healthcare provider is providing for the patient" the same way they offer a patient portal they might offer an integrated App.

And depending on the way those organizations are legally structured, you know, that App developer might be a business associate with the hospital for example or not.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

But in the open sort of consumer-facing world where a consumer picks an App that they want to use, in the general case that App doesn't have any prior connection to the healthcare provider organization.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Exactly.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

It's a standalone thing.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I think it would be helpful...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

And there are special cases where that connection does exist.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

One of our recommendations might be, if they don't already have, you know, a very clear definition, you know, in this guidance that they're providing of what they mean as a third-party App. I think it's what you said Josh, which is, somebody who is not native to the EMR domain who develops an application that's consumer-facing, but I could be wrong.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

I like that...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

And there is.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

This is Aaron Miri, as a provider I like that definition, what you just said, because that's very clear, very easy to understand and I'm thinking that for my legal teams and immediately they're going to say "okay, do we have a BAA, do we have all these structures in place" but what you just said gives a very clear definition of how to appropriately go about it.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Exactly because if it's something that the provider is funding or it's offered by their EMR and they've got it as part of license then we need a BAA in place and it becomes burdensome. That's just a new friction, an additional friction that I...

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

We could...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

We would address, but it wouldn't...

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Adoption, you got it.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah, it wouldn't make sense for all third-party Apps that don't have a contractual relationship as a BAA to the provider or payer any covered entity for that matter.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well, what we don't want to have, this is Leslie, is confusion which Aaron brings up a really good point, because a vendor acting as a BAA of a covered entity may have an App that they want to provide to a patient...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And not have to fulfill their relationship in their BAA but a separate relationship that is a consumer App and so understanding what that line is will be important so that we can get as much adoption both from the HIT world and the consumer world without...with equally open and lack of impediment.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Bingo, you've got it.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I think that is an incredibly important point, Leslie, thanks.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

This is Yak and maybe not to keep going down this rat hole, tell me stop if I should, but aren't we also concerned about APIs for second-party Apps? In other words, applications that are provided by a provider through their EMR, let's say a patient portal with an API, are we concerned about that? Would we call that a second-party App as far as it's security and privacy or are we really just looking at third-party?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Well, I think if we look at...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Well, if it's under the BAA...if it's under the BAA agreement they have all of that protection that's already associated with that, right? So, if it's truly a third-party App it should be connecting with no other special terms than any of the third-party App that's connected to the API at the patient's choice. The patient might be more comfortable choosing an App that the provider endorses somehow but...

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

True.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That endorsement could be a brand endorsement and not a technical endorsement that limits others from participating in the ecosystem.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah and just to throw in...so my interpretation of the charge is that what we really need most urgently to address is this case of third-party Apps and as Leslie said some of these challenges go away in the case of second-party Apps or third-party Apps that would be third-party except they're bundled up by the provider. So, if we can provide a coherent set of guidance around third-party Apps I think that we will have met our charge.

And the last thing that I'll say is there is clearly a gray area here. I've even seen patient portals that are...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yes.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Offered as the VDT solution by a healthcare provider organization that actually implemented through a connection to a third-party vendor where patients in order to see their data in the portal first have to sign an agreement that they understand that this is not a HIPAA covered entity, the portal provider, and that they're willing to have their data sent into it on their behalf. So, there are certainly gray areas here.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

All ears run amuck. I hear you.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

That's where all of our questions come from those experiences.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

So, Josh, is it part of our role to help define that and clarify that in our recommendation?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I believe it is. I think that we should certainly raise the point that we don't see a clear definition of what a third-party App is, possibly it's there and I've missed it and I'll feel especially embarrassed if it's somewhere obvious, but that's always very possible. But we should certainly call out that issue and we could provide some guidance about what we think a third-party App should be defined as just to be clear about our expectation there.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Yeah, I think it's very useful for us to do that.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I do too, I do too.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

As a CIO I would have to go argue for this and allow for this, trust me, the more clear we can be the easier my life is to push adoption.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And I think we had formally asked, last week, to have ONC provide clarity on this legal area, the gray area, with regard to HIPAA, no HIPAA, BAA, no BAA and also just perhaps even ONC did some wonderful work on the notice of privacy practices as a model for others and in that same spirit perhaps we could look at, in our recommendations, that ONC help provide a model of notification, warning, buyer beware, whatever you want to call it...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That we adopt it by others.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Or at least a reference tool, right?

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

So, just a quick note on that.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Exactly.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

OCR will be presenting at our next meeting, we've set aside 45 minutes for them, we can ask questions like that. The ask was for OCR to clarify issues including data ownership, patient access rights and HIPAA BAAs, Business Associate Agreements.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Wonderful.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Department of Health & Human Services

Hi, this is Linda Sanches from OCR. If there are other specific things you'd like us to address in two weeks please let me know.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think...I don't know Linda if this is...this is Leslie again, I don't know if this is your area but I think we're touching on this later in the slides and that's what was brought up earlier, which is the level of assurance and identity management looking at the rules and regs and looking at the current standards we really don't have a policy statement on the level of assurance required for a patient to be identity proofed at the provider's site whether that's LoA 2 or LoA 3 and I think that would be worthwhile to know if there is any legal consideration we should know in making those recommendations for standards for that.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Department of Health & Human Services

Okay, thank you.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

There is...Linda, just for your information, the HIMSS Identity Management Task Force...a recommendation that might be useful, I'd certainly love to...

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Department of Health & Human Services

I'm sorry, you're cutting out, I missed what you said?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Oh, there's a Task Force from HIMSS working on this specific question about what identity proofing is required to disclose data to a consumer and it's going to be done by the time of HIMSS, it would be great to have your feedback to inform that as well.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Department of Health & Human Services

Okay, sure.

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

And this is Rose-Marie from ONC, just to mention, we have been working on that topic for quite a few months now and we are putting out...we will be putting out a policy statement on the level of assurance and credentialing for patients, our focus is on patients and that will be coming out probably in the next few months. Thanks.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Rose-Marie, will the timing of that be aligned with this or do you think we'll see that...we only have a couple of months here for the recommendations?

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

It's sort of aligned but we need to give 60 day's comment period. The goal is to have it reviewed by SLC by end of March so we're looking really...it's going to be probably after April, sometime around May/June timeframe when it will be released but the process is to get it in by the first week of March and end of March get it approved through clearance.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Well, we've...so let's run through the next couple of slides and then get into some of the key themes from the hearing. I think this was extremely helpful to walk through the CEHRT criteria and the next slide, slide eight, provides that same opportunity just a refresher around what's actually in the Meaningful Use Stage 3 Final Rule.

The API is referenced in two objectives, five and six, patient electronic access to health information and coordination of care through patient engagement, which there are four basic actions that a patient

should be able to take and this is the view, download, transmit and they've added and access their health information through an API. So, I thought that it would be helpful to see, you know, what the certification criteria was as it aligned with what the Meaningful Use requirements were.

So, on slide nine, I think this is probably self-evident with some of the discussions that we've had, but, some of the key items for consideration, again, privacy and security issues for adoption of open APIs focusing on read only APIs based on that 2015 health IT CEHRT criteria, APIs in the context of consumer-facing Apps including VDT and patient access and then single patient access to the common clinical dataset.

And I don't remember if we...if this is anywhere throughout the slide, but wanted to reiterate that this is...these are not APIs that are dealing with aggregated data or for any other purpose that this is specific for patient access and it is a single patient access to their common clinical dataset.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I have a question...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But that does allow for all data of that patient to be downloaded?

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Yes.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

All data in the common clinical dataset.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

In the common...yeah, yes.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Perfect, thank you.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Meg, this is Aaron, I have a question and it...I might not understand, if there is an API that allows me to schedule an appointment with my doc that's separate from what's in scope? That would be outside? Anything like related to scheduling or some of the other MU criteria or is that in scope?

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Well, Josh may have thoughts on this as well.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So...

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

I think...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Oh, you guy's talked...

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

The quandary...go ahead?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I'm sorry; you guys' have already talked about it that's good.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

No, no, no, no but I think that's an important question. So, on the three objectives of the Task Force I would put that in a third bucket and that, you know, really any barriers or opportunities around consumers accessing their APIs.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Okay.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

So, while we're probably urgently focused on the patient access I think that as we discuss the things that may inhibit that in other use cases I think we absolutely should.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Okay, so we're thinking about it.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I think it should be...I don't know what, but to me a user's experience shouldn't be complicated because we're focused on one thing if we can make it simple to do those other things that are also required by MU. I think...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, my general...my general sense and what I'll suggest as we begin formulating recommendations is that we provide a set of...one set of very narrow recommendations that are specifically aligned to the 2015 certification criteria and Meaningful Use Stage 3 objectives where we say, you know, if we want this stuff to work in the coming two years these are the things that need to be addressed right now otherwise it's going to fall apart and then a broader set of recommendations that think beyond just the letter of what's described in today's certification program and do begin to address some of these broader issues of user experience of additional APIs and capabilities.

But I want to make sure that we can really segregate out the stuff that is immediately applicable and without which we don't even think the current...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

API certification criteria is going to lead to data access.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

That's a smart demarcation.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Any other questions? We have one more slide that kind of is meant to frame our discussions a little bit and it's "out of scope issues." So, in addition to the key considerations and, you know, the Task Force objectives we've specifically had these items called out as ones that are being addressed elsewhere.

So, specifically, terms of use, licensing requirements, policy formation, fee structures, certifying authorities, formulation of standards, electronic documentation of consents and issues unique to write APIs versus the "read" and, you know, I think that I'm not viewing these as specifically hardline.

I think that if we bind ourselves to having a discussion around...that may lead us toward a recommendation around considerations for terms of use for example, as a broad example, but I don't want to not have that discussion, I just think that, you know, considering that we have three meetings left before our draft recommendations to the Policy and Standards Committees I think this is intended to really help frame our discussion for the best and most efficient use of our time.

So, it sounds like a lot...we're kind of...the whole front end of this is to really kind of frame the structure and then starting with the next slide on slide 11 we'll talk a little bit about the key themes of the hearings and hopefully we'll flush...and we'll grow into that and, you know, based on the discussions that we have. So...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Meg, Meg...

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Yes?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I have one question on the previous slide there was a...about electronic documentation of consents required by law or policy and in my mind the way that the API model works, if I understand it correctly, the consumer is consenting to receiving data so we would touch on consent we're just not going to dive into, you know, do we need to have a document that the consumer's sign before I can disclose it and all that.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Yeah, my read on that is we're not going to be worried about the computable format of the consent, but if Rose-Marie or Jeremy if you wanted to clarify that?

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

Yes that's correct Meg. We wouldn't be touching computable privacy which is the whole consent management...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Oh.

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

Between basic choice and granular choice so we'll focus our recommendations on just general ideas of consent meaning the patient's App of choice without going through the whole consent topic but we can definitely discuss it, but keep it streamlined to our focus area.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Got it, so like parenthetically after that we're specifically not talking to how do you enforce personal privacy preferences at the granular level?

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

Correct.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

That consent is implied when the user authorizes the provider to disclose data to themselves. I'm with you.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

I...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, as we...sorry, go ahead.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I broke Meg's flow, I'm sorry, Meg.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

That's okay, I'm actually...Josh is up if you wouldn't mind, Josh, picking up from slide 11 the key themes.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Sure, so I'm going to pick up as we go through a synthesis of the themes and this was put together by the team who is helping ONC to put together...to provide support for this workgroup and so I would look at this as a first pass over what these themes are. Meg and I reviewed these over the weekend and provided some early feedback but this is by no means set in stone and I just want to provide an overview to the themes that we've identified so far.

I'm going to be talking through a whole list of slides and that always makes me a little uncomfortable so what I'll probably do is pause after each one for comments and discussion and that said I may cut off comments and discussion because if I don't we won't have enough time to actually go through the list.

With that I'll make one more comment about the previous slide before I dive forward and that is that, you know, there's a lot of things on this list of out of scope issues including details that we heard about in testimony and details that we'll be talking about as we summarize key findings. So, those include things like certifying authorities and licensing requirements and issues about write APIs for example.

And what I will say is, while we're not charged with addressing any of these things head on I am quite confident that as we do address our charge we'll be sort of bumping up against these issues and we'll find ourselves saying somethings about them just as we go through our regular charge. So, I wouldn't expect these things, even though they're out of scope, to be unmentionable as it were.

So, with that let me dive into the slide that's labeled general support for API adoption and this is the first theme that we're picking up across the panel and this is a synthesis of the sentiment across the panels that APIs are, on the whole, generally a good thing. We didn't hear anybody chime in and say "we think APIs are going to be the demise of the healthcare industry."

Nobody said that they thought the risks of using APIs at all outweighed the benefits and in general we heard people make just the opposite comment, which was "yes, there are risks to deploying an API but there are also risks to exposing healthcare data without an API." And sometimes APIs can give you more effective tools for mitigating those risks, things like centralized authorization and security and centralized audit logging so you can detect if anything goes wrong.

And in general there was an acknowledgement that even though there are risks at the same time there are benefits to the kinds of data sharing that APIs allow and that those benefits are widely seen to outweigh the risks. We didn't really hear anybody make the counter argument there. So, we heard from consumer health tools, from general consumer-facing companies, we heard from healthcare provider organizations and consumer advocates, in my view at least, unanimously on that point.

So, I'll pause on this slide, general support for API adoption. I think this stuff is pretty much motherhood and apple pie but please if anybody, especially has a counterpoint to make on this slide, chime in now before we go on.

Okay, I'm going to press on then to the standards slide and this is an area where I think we need to probably sub-divide the theme in order to provide a more nuanced view here. But we heard about lots of standards from the various participants in our public hearings and in particular we heard about standards for healthcare data and the way that data are normalized so that they're consistently

described across different EHR systems and we widely view that as out of scope for our charge even though we recognize that it is critically important and we said “we’re not solving the problem of standardizing healthcare data here in this Task Force. We have enough problems to solve and that’s not one of them.”

But then we also heard some comments about security standards for doing things like authorizing an App and these are standards like OAuth and OpenID Connect and User Managed Access. So, I think we need to be careful to tease those two things apart.

We heard, probably more, on the former piece, the clinical data, which is out of scope, but we also heard some on the later piece which we’ll get into especially in some of our later themes here, but many organizations identified that the lack of standards in general made it more difficult to provide wide-spread data access.

So, again, let me pause on this slide before I go on and see if there are comments or reactions on this theme?

All right, I’ll press ahead. So, the next slide is about identity and access management and we heard from a number of panelists about challenges of identifying who a user was both in terms of tying back to their real-world identities and then also in terms of providing a way for users to authenticate electronically to their account, for example, the way they would sign into a portal to access their data online or to approve access to an application that they chose.

And so we heard from panelists that there are places in the ecosystem today where there are very mature and robust techniques that have been deployed for identity management, especially on the prescriber’s side, we looked at ePrescribing technology as one example where there is a pretty thorough but healthcare provider-facing interface for doing things like patient matching and of course there are different tolerances for patient matching when it’s a healthcare provider who is using the interface.

In general we expect that it is, in some cases, okay to use things like probabilistic matching where there will be errors where there is a provider in the loop who is actually in charge of interpreting those results and we’re not sharing data with patients about other patients.

And there may be different requirements that apply when we’re talking about sharing data directly with patient’s higher standards for that kind of identity assurance before data are shared.

And we heard from panelists that when it comes to APIs, yes, there’s a need to verify the identity of the patient or the user behind the App and then there are many open questions about how strictly we need to verify the identity, as it were, of the application itself. Is it okay just to know who the user is and the fact that the user approves or do we need some sort of deep assurance about the identity of the App at the same time.

We heard from some provider organizations who are working with patients today on the subject of recommending Apps and, as we touched on earlier in our discussions on this call, some of the considerations change when a provider organizations is actually offering an App to a patient rather than simply recommending that a patient might want to try it. We sort of jump from this third-party to more of a second-party scenario.

And then we heard from patient privacy rights that there are some equitability issues involved in offering different APIs or different kinds of data to patients and providers and we heard the perspective that it would be...that it is an important principle to make the same interfaces available to patients as well as providers.

And we heard that when it comes to providing clinicians and patients access that the User Managed Access specification might be helpful in those use cases.

So, a lot to think about in terms of identity and access management. I think some of the points that are on the slide right now are actually more about authorization and access control and it may be worth trying to tease this out into a couple of themes, but let me pause and see what the responses are to this theme on the list right now.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Josh, this is Aaron, I think you mentioned it in...when you were reading this, but I don't see a bullet calling out the comments we heard about identifying the Apps.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, I think that's a good point. I think we need to explicitly call these out as two separate issues, how do you identify users versus how do you identify Apps.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I think in the testimony we heard there was somebody making reference to a three-legged stool and, you know, the identity of the patient, the identity of the App and I believe there was a third one I'm not sure what that was but...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Well, I would guess maybe the provider organization. In general we talk about an OAuth process as three-legged for exactly that reason because there is a user, there is an App and there is a service provider and OAuth is one protocol that brings those three parties together to allow access control decisions.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

So, you know, one of the questions that gets begged here is, there are Apps that are offered, you know, serve a multi-tenant, many consumers and there will hopefully be Apps that support individuals who want to, you know, own and operate their own application as advocated by PPR and being able to figure out how do we manage the identity of those applications so that it is seamless to the consumer is important.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Josh, this is Leslie...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Right.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It is worth talking about identity and access management...we heard both about remote authentication I think someone mentioned what LabCorp does to do that today at about a 95% confidence rate, completely remote authentication, but an identity management, but what about the in person, in face-to-face that providers currently do in practice and currently they're taking a patient's identification and they're taking an insurance card if there is one and validating the patient is who they say they are. Do we want to talk about both of these processes and what process would lead to an LoA 1 or 2, or 3? Do we need to call that out?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I think we do, certainly. I think that's a key part...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, I mean...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I think it's adoptable in the long run, right, at least initially.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I think it's worth our discussion to be sure. In general when I look at some of these problems one lens that I like to look at them through is how do we solve this today with patient data access through a portal and so through that lens I can say "well, each provider organization has solved this problem somehow" at least they have found some way to provision user accounts for their portals, but I think it is absolutely worth our trying to catalogue the different ways that is done today especially if we want to share considerations about whether we think the most stringent ways are appropriate.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

And again that HIMSS Identity Task Management Identity Management Task Force has drafted some thoughts from the industry leaders involved in that space that might help inform that if we wanted to look at it.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, this is a big topic but I'm inclined to push forward here unless anybody else had a comment they really want to make on the call right now and we should absolutely follow-up over e-mail if there is additional discussion. Okay, let me push forward because we have a number of additional themes to go through.

So, this is a short one on education and resources which is a number of questions came up on the subject of educating consumers and providers about what APIs are and what the rights of consumers and providers are, and about general practices for protecting data and so there was a discussion about the fact that App developers need to communicate their privacy policies and their terms of service to consumers in a clear way.

And that in general concerns for resources to educate providers and the staff are a real challenge especially for smaller practices where they're struggling to keep up with a lot of new programs of which patient API access is only one small part. So, again, let me pause here on the education and resources slide and see if there are reactions or comments, or questions there.

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

Hi, this is Ivor, I apologize that I missed the second hearing because I was in clinic. I do have a question about this and I don't know if it was discussed, the sort of level of literacy and the need for real simplicity when talking about privacy policies in terms of service and making it really clear to consumers in how it is presented. Did they talk about that at all?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

I think, you know, Ivor briefly it was touched on, you know, and we talked about the need to...the benefit of...that is something that might be a good thing for a government entity to help produce.

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

Yes.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

We've seen it in human research protections for IRB training. I think there might be a similar benefit for us to, you know, encourage the government to produce some educational materials that everyone could use and have a common theme and have it produced at the right level for all types of consumers.

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

Yeah, I worry about this sort of language of having it be in the developer's hands.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah. All you need is your OAuth key what are you crying about?

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

Yes. So, I just wanted to check and the same applies to sort of the small practices versus large organizations. So, the same sort of principle applies. Thanks.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, let me press on ahead to the slide of granularity and permissions. And just to provide a little bit of vocabulary here, when a patient is allowing an App to access data the basic question here is, to what extent can a patient subset the data out? So, I want to give you this but not that. So, I'll use the term permissions to say "well, I'll give you permission to see my medication list but I don't give you permission to read my lab results" that's the sense in which we're using the word "permissions" here. And then the question is, well, how fine-grained are those permissions? Is it all or nothing or can I make some very narrow permissions?

And in OAuth the term that is used for this is called a scope, a scope of access. So, when you approve an App you approve it with certain scopes. So, you'll see the word "scope" appear here in parenthesis just to indicate that this is another term that is sometimes used to describe these fine-grained permissions.

So, with that vocabulary out of the way, at a high-level what we're talking about here is the fact that Apps or APIs can permit access at varying levels and it could be based on these scopes which a user might explicitly approve or it could be based on some automated decisions like who is it that is accessing the data, what do they need or what should they need for this particular use case.

And we have seen that some interfaces provide a user with the ability to make these kinds of fine-grained decisions and even in the consumer world we see a pretty strong diversity in this area. So, we see some consumer APIs which are sort of all or nothing like versions of Android sort of in a 4.0 series and earlier used to just present an App with a list of permissions and the choice was you could install it in which case it will get all of these things or you can decide not to install it.

And then there has been a transition in the mobile world, in iOS as well as Android, towards Apps where their permissions are separable. So, I can install an App and say "yes, I do want to share my contacts" but "no, I don't want to share my location" for example.

So, those are the kinds of issues we're talking about here in the healthcare space as well as in the consumer world. And so there are some basic questions about what kind of granularity the APIs should support, what do we need in order to enable the kind of ecosystem of data flow that we're seeking out here?

This is not an issue that's explicitly addressed in ONC's certification criteria today and so I think today it would be possible to provide an API that just didn't really address this issue at all where the only level of permission was "yes, you can have access to my data" or "no, you can't." And that I think would satisfy the certification criteria pretty handily.

And the question is, you know, for our group, whether we think that's enough, whether we think we need a finer kind of granularity to these permissions.

And another thing that we heard, in terms of the testimony from panelists, is in terms of API management, in terms of the security protocols, you know, we've got standards like OAuth and OpenID, and these APIs have the ability to limit access and that can be based on scopes or it could be based on other kinds of policies.

My sense is that this last bullet point here is really not part of permissions and scopes, maybe this belongs somewhere else in the discussion like access control. I'm not sure that fits directly in with the theme. We should think about relocating that one.

Before I pause for questions though let me go onto the next slide which is a continuation on this theme. So, we heard from a number of organizations that are using some of these technologies that are using OAuth and OpenID, and User Managed Access.

So, we heard from a group at NIST who is working on the Green Button specification that allows consumers to share their energy usage data with applications. So, there is a lot of parallels to the Blue Button world and in fact a lot of the work on this project was done in a way that took advantage of some

of the earlier design work that happened in the Blue Button community. And in this world patients not patients, sorry, but energy consumers use this Green Button API and use an OAuth process to approve a third-party App to access their energy usage data.

We heard from Eve Maler at ForgeRock and Eve shared a position about OAuth where she says in general the kinds of permissions that OAuth lets you make are coarse grained and doesn't put the patient at the center of care. And that in Eve's perspective a specification like User Managed Access allows for some more granular use cases and allows for patients to make different kinds of sharing decisions.

On the other hand, we heard from Apigee that they use OAuth across their API management platforms and from their perspective OAuth is very flexible and effective and that the use of OAuth scopes is in fact a good way to allow users to narrow down the permissions that they share with a given application.

We heard from Imprivata about the importance of a specification like User Managed Access for allowing secure data.

And we heard from the US Digital Service with a comment that APIs are widely used within systems in a variety of networking protocols and with lots of different security mechanisms and that it might make sense to certify these different aspects of an API with different levels of stringency.

So, for example, we could have a very strict and narrow set of certification criteria about the way an App gets authorized but we might leave a broad and open set of possibilities about the way that requests and responses get serialized. We don't have to define all the levels of the stack at once in one single set of rules but we can address the areas that are the most standardizable early on and then over time whittle away at some of the additional layers of the stack here.

So, that's a set of perspective around granularity of scopes and permissions. Let me pause there and see if there is comments or feedback on that theme.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Hey, Josh, this is Meg, so you mentioned the scope is to...I think you used the example access to my lab results for example, so access to that given resource. What are your thoughts around sensitive data within that? So, I want to grant access to my lab results but only these particular lab results not the ones related to an HIV diagnosis. How does that fit in with the definition of scope or permissions?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, so in general this is an area that we can talk about as scope design in the OAuth sense, which is, you know, how do we break the world down into a set of levels of permission, a set of scopes that is fine-grained enough to let us do what we want and not, you know, so fine-grained that it's impossible to implement in a real world system.

And the example that you just gave is a perfect one to illustrate the sort of fractal complexity of this space. It is easy to sort of sub-divide any one of these scopes and say, well, actually there's a lot of interesting distinctions even within this category and lab results is a perfect example there.

And in general some of these things can be very tricky to be precise about. So, for example, the fact that I'm sharing my medication list might inadvertently give away my HIV status or it might help somebody

develop a probabilistic model which increases the likelihood that my HIV status is positive. You can give away or leak information in all kinds of ways.

And what we're talking about with scope design is relatively rigid, we're saying "yes, I'm going to share this information with you" or "no I'm not." And the inferences you can make from this information or from this information joined with other bits of information you might have about me, those inferences are much harder to get a grasp on.

So, the fundamental question here is, you know, what are the kinds of scopes that we can lay out that will be implementable and that will also provide users with enough protection that they feel comfortable that they can run an App and not be over sharing and it's very content sensitive, it depends on who the patient is and what App they're using and how much they trust it. I'll say at the same time...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Josh?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Let me make one more comment and then open up. So, that was...the last thing I was going to say was when it comes to the levels of access that are described in the certification criteria today, as I said, there's nothing about the scope of approvals but what there is...one thing that is described in the certification criteria is the scope of an API request.

And so an API request from an App can say for example "get me all data of a particular type." Like get me a list of medications or a list of problems, or a list of lab results. And then the only filters that are explicitly described in the certification criteria, I think, are date-based. So, get me all medications from the last year. There is not a...notion that an API would have to say "get me all medications except if they have to do with HIV" for example. The level of detail does not go that deep. And there...sorry, let me pause, I know I cut somebody off.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

So, Josh, this is Aaron, and first great use of the word "fractal" love that. But second I think there's a more fundamental question about scopes and where they should be applied, and maybe I'm looking at this in an inverted way and it has to do with how our charter is defined.

I think when we get down to fine-granular disclosures that's closer to the patient than the provider and it probably, you know, at least from some of the research and work that I've done in that space, easier or more accurate to implement on the consumer App than to assume that the provider who is the holder can disclose at that level.

So, you know, in my perspective where I've seen granular controls become more successful is where the consumer has access to the entire dataset and then applies those types of scopes. I think trying to apply those types of scopes to particular provider entities because of the variance in interpretation of some of our regs result in unacceptable errors. So, I guess one of the...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yes...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Fundamental things I'm asking is, do we really want to get to the point where the provider is deciding what is substance abuse data and whether or not to share that with the consumer. Why wouldn't that be something that we put closer to the consumer to decide from the App of their choice?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, just to cast...so, thank you for the comment Aaron and I won't say that I disagree with it, but let me just cast it in stark terms to try to characterize it. One way that I could characterize what you just said is, you know, actually it's good enough for the EHR just to have a share all of my data option and that's the only option. And then, you know, it's up to me...after my data gets shared with an App, you know, it's up to me to use that App how I want.

And if the App is able to re-share data with other tools maybe that App will give me lots of nice fine-grained permissions. But if I want to use the App I have to give it permission to see everything in my record. And I'm not saying that's wrong it actually might be a totally reasonable first step, but it does change the set of Apps that I would be willing to trust in those circumstances.

There are a lot of Apps the I might trust just to see my immunization data and nothing else and I would be willing to run an App that I didn't trust very much if all it was going to learn was what immunizations that I'd had but I might think long and hard before I approved it if my only option was to give it everything about me.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Yeah, and Josh...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I'm just asking the question because this is...

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Josh, this is Aaron Miri, I totally agree with you. As a provider I can tell you that hospital organizations, healthcare organizations are reluctant to share all just due to the fear of simple liability of what's in there and any simple mistake can be taken out of context and eventually end up in court. So, I totally agree with where you're coming from Josh.

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

Yeah, this is Ivor...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, this is Leslie...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I want to...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, the first scope that we see though is downloading some or all of a single patient under the common clinical dataset, so it's a very, very narrow scope, correct? But I think the recommendations that we heard or when we would need more specific information or additional information that they approach using UMA with some granular consent might be a hand-and-glove recommendation so that even if we were to go forward with this current abbreviated use case, which is...includes to Aaron's point, a buyer beware clause any sort of future look beyond that would have to include some sort of granular specific consent and use.

But it is difficult because the regs do say, this is a requirement and there can't be any specific...it's going to be up to the patient and therefore the patient gets to choose how that data is used in the App of their choice. So, remember...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's them exercising their rights, it's not us determining what they have the right to.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Right.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Let me make two quick comments in response to that, thank you, Leslie, I think this is...you're outlining a couple of issues we really need to tease apart.

And so the first comment is, when it comes to these fine-grained scopes there is no question in the certification criteria that the API needs to support access to everything in the common clinical dataset, that is a given.

The question becomes would it also be good for the API to allow the patient to impose limitations on what any particular App could see and if that would be good should it be required or is that just a good practice and should it be sort of standardized so that we say, here are the levels at which we think a patient should be able to impose additional restrictions or maybe we say, it's good enough here in 2016 to just get some data flowing even if the only decision the patient has is all or nothing. But no question the certification criteria says the API has to support allowing everything. It's just a question of whether the patient ought to be able to dial it down in any particular case.

And then the second comment I wanted to make was about what it would take to provide those finer grained scopes and just as a sort of point of clarity or information, OAuth, as a specification, gives us the tools we need to do fine-grained scope design, you know, we don't need to go to User Managed Access in order to provide that kind of level of fine-grained scopes, it's really the limiting factor is whether a

provider organization is even able to segregate their data according to these scopes. So, OAuth gives us the tools we need for that.

The use cases where User Managed Access becomes important is when a patient wants to use an App not by herself but wants to give access to other people using different Apps to access her own data and wants to make those decisions in a central place. So, UMA is really a different kind of beast which allows some other use cases but isn't needed just for fine-grained scopes like we're talking about here.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

So, Josh, this is...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you, Josh, I appreciate that.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

You know if it was 2021 and we had some broader experience applying OAuth that way or applying UMA, you know, I would be overjoyed with the idea of the provider system taking on the responsibility of doing that but we're not that far, you know, we don't...I think our recommendation should be, could be, ought to be, you know, encouraging and supporting early stage pilots that use that at a broader scale than what we've seen in the demonstrations to date.

But I worry about coming out with a recommendation that the nation has enough experience in using these things, these kind of technologies to push that burden onto the provider's system.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah...

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

Yeah and...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

I'll...

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

This is Aaron Miri, I would say...and then the nation has enough case law to support doing it the right way, because again, it comes back to a legal question unfortunately.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yes. And, you know, one of the things that I hope, and I don't know that we'll get to, but that there would be a...to me there's an implied safe harbor when a provider discloses the entire common dataset via the API that, you know, they have some legal protections but I don't know if it's strong enough or implied enough in the MU or other regs that have been documented. But I totally...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah. Well, that's an area where I agree we need clarification but, you know, from my perspective it seems obvious the clarification we need is that a provider organization is not responsible for what happens downstream after a patient says, please share my data with a particular App.

So, the issue about scopes is not really about protecting a provider organization from liability there. The issue about scopes is about making it easier for a patient to run Apps that they don't trust quite as much and the reason they might be willing to run the App is they knew it would only have access to a small amount of their data. But I take your point Aaron that getting these details right is very challenging.

Let me provide just one more piece of background which is the way we've addressed this in the SMART Health IT Project that I work on at Harvard...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

And what we've said there is, we want to provide some level of fine-grained scopes but we also want to make it not really a judgement call for the provider system, we want to make it sort of dead simple...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Yeah, yeah.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

About how these scopes work. And so what we said was we're just going to segregate the data, in that case we used the FHIR API to share data, we said, we're just going to segregate it based on the FHIR resource type, so if it's a FHIR medication, you know, there's a scope that says, you can read my FHIR medication objects and if it's a lab result there is a scope that says you can read my FHIR observation objects. And we just segregate around those very technical lines in order to allow patients to say, here's the resource types that I want to share and here's the ones that I don't.

And, you know, back to Meg's point, this does not give a patient the power to separate out sensitive lab results from non-sensitive lab results because in a lot of ways that's a judgement call and we don't think that provider organizations are going to be able to make judgement calls but we think that they probably should be able to make these very technical unambiguous distinctions about segregating resource types because they need to be able to do those segregations just to be able to respond to normal API requests like get medications or get problems in the first place. So, that was sort of a pragmatic line that we drew.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

That's very pragmatic, I like that and I think it has legs. I would just suggest maybe turning your focus rather than trying to create those API scopes specific to the EMR why wouldn't you make or be able to make those scopes specific to the consumer's chosen, you know, PHR-like product? And then have the...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

That's...

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Immunization App go to their PHR rather than going to, you know, multiple providers where the immunizations may have occurred or may not.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Sure and I don't think we have time to drill down on this, all I'll say there is, if the patient actually had a personal health record that accumulated all their data across various providers then that would be a great direction.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Well...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

But in order to enable that, you know, we're still dealing with the fundamentals of data access.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

I think you're right.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

But I get your point Aaron.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

This is Aaron Miri and I can just give you some real life examples real quick, you know, I was part of the IGNITE Project from the ONC a couple of years ago where we actually offered up through a PHR access, access to our EMR and one was patients being able to input their information but two was ease of access to the EMR because the EMR vendor was not forced to have to share data via a common structure like an API.

So, I agree with what Josh is saying it's going to be a lot easier to have adoption if those mechanisms are in place to allow for the consumer to even have a choice.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, I'm going to apologize twofold, one is because I feel like I've monopolized the conversation around scopes a little bit and second is that I'm about to cut it off because I think we need to press forward if we're going to get through additional themes here. So, I'm going to push on through the next slide which is consent.

And the general theme here is, so panelists overall recognize that when an App is going to seek data about an individual, and if the App isn't used by that individual, then whoever is hosting that API might want to confirm that it's okay to release these data.

So, most of the use cases we've been talking about here today are about Apps that an individual like a patient would use or approve but of course you can think about stringing those things together in interesting ways.

So, for example, as a patient I might approve an App to act as my data but the "App" that I'm approving is actually like a healthcare provider across town who is going to give me a second opinion and by approving that App I'm effectively sharing the data with the developer of that App which is the healthcare provider across town. Those are the kinds of use cases that we enable by supporting an ecosystem where patients can choose whatever App they want. So, there are an interesting set of issues around consent that arise there.

At the same time, in the 2015 rule there is this notion that App registration has to happen. I'm not sure I understand this point about documenting the required consent and so for me that's a point where I need clarity. I don't know how to interpret the middle bullet on this slide.

And then finally, for Apps that are used directly like an App that a patient would actually be the front-end user of there's a question of whether this is a different story on the consent side and when I want to use an App and when I approve that App to access my data this is the scenario that feels the most obviously like an OCR sort of access rule issue. And so there is this spectrum that we might want to identify here. So, let me pause on the consent slide and see if there are other reactions to this.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Josh, this is Meg, I'd like clarity around that second bullet as well so that's interesting, at the time the App is registered that's when the required consent could be documented? Is that...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, I...

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Do you want to be able...

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

My guess is that this bullet point is a mistake because I don't have any way to interpret that in which it makes sense to me.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

You know I think this is back to...this is Leslie, it's operationally so as a provider saying, yes, we're not preventing any access but we want to know that the patient has actually been...knows their risk and has consented to receive that data.

And it's not...it's really made with the wrong language but I think we heard over and over again the concern about education and understanding, and I think that's a legitimate concern and may or may not require something back to the provider that says, hey, I understood my...and I consent to this. But I do think that's worth some further discussion.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah, I think it's a great point and then when it comes to OAuth as a technology for these approvals one of the nice things about OAuth is it can actually be the provider organization itself that puts up the authorization screen that a patient would use to approve the App. And as part of that process where a patient is approving the App the provider can ask the patient questions, it could even test their understanding, they could display warning language and the provider organization is in a position to actually customize that approval experience without getting in the way of the overall standards-based flow. I think that's an important area for us to highlight when we think about what are the aspects of the user experience that we believe should be captured in that approval step.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Thanks, Josh.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Let me push on ahead to the certification slide, this is one that's labeled certification or a Good Housekeeping Seal. This is an interesting topic that we heard about from a number of panelists in the context of what Apps they saw fit to run in their system and in some sense the question of certification is an interesting one in the first place because if it really is a patient's decision about which App they want to use and what does it mean for an App to be certified isn't that just a way of telling a patient that they can't run certain Apps because they haven't been certified and is okay to do that.

Or alternatively you could look at certification through a different lens. You could say, certification is a way to identify the Apps that a provider organization "trusts more." And so if a patient goes to approve an App the provider organization might give them extra warnings and scary language if the App wasn't certified they might say, you know "look out, be careful, you're about to approve an App that we don't know anything about and we can't vouch for it" versus an App that was certified where they might tone down the language and say "you're about to share your data with this App, we've heard of it before and we think it might be trustworthy for the following reasons, but of course it's your call."

So, there are different ways to view what a certification process would mean. And so we heard from organizations that today do a lot of deep vetting of applications even for their in-house use and so organizations like care provider organizations that only allow a limited number of Apps within their system and these are Apps that, you know, in some cases have been reviewed down to the level of source code and for which they have business associate agreements in place, and, you know, a lot of criteria and conditions that go onto the decision of whether to enable that App.

We heard from organizations that felt like they didn't have the bandwidth to make those kinds of assessments and decisions in-house and would really appreciate if there was a third-party organization or a set of third-party organizations that could help to make some of these determinations and if they could then outsource some of that work to organizations which could be very formal certifying bodies or could be rather sort of informal endorsements, or some mixture, maybe it's even a secondary market of this kind of advice about which Apps are trustworthy and in what ways.

You might have an organization doing these assessments on the basis of security and another organization doing these assessments on the basis of clinical relevance and you might sort of overlay those two perspectives to get a set of Apps that you trusted from multiple perspectives.

And we heard from organizations as well thinking about Apps when it comes to terms of use, what these Apps were going to do with the data that might be one of the factors that flowed into this kind of approval decision is to ensure that an App was making it very clear what they would and wouldn't do with the data that it collected. So you could have sort of a terms of use seal of approval as well that you could overlay with all those other perspectives.

I think this is a rich category and it's one that we technically labeled on our out of scope slide, but I think it's something we're going to have to grapple with at least at the level of some basic recommendations about how to take the ecosystem forward and what the roles of certification should and shouldn't be, and what different types of certification we might want. So, let me pause there and see there are other thoughts.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Josh, this is Aaron, I mostly need to recuse myself but I think that the bullet that was in the center talking about registration as a means of documenting the consumer's authentication might relate to this in the sense that as you register the App, you know, you've captured an identity of that App and it's end users and that this might be a source that can be referred to by the discloser as why they believe that their client's authorization was in place.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and I struggle with this in both...both positively and negatively. The idea of a Good Housekeeping Seal is one that is used when you can't trust the industry as a business and often times people regard that what the provider is telling them to do is highly trusted and so there is somewhat of a market precedent that says, I go to the site my doctor tells me to, I read the education my physician tells me to, I trust these things.

So, I wonder if the market then will have a...the providers will say, hey, these are the Apps we support and chose and we want you to use that and they consider that potentially a competitive advantage because they've chosen these wonderful Apps that work within their API both the open API we're suggesting and proprietary APIs that they might already have in place, so they have an App store that covers all of that.

Whereas we might have a very small provider, single practice guy, he's not going to vet anything and he wants a go to source that says, hey, I know this won't break me. So, I think there are those two extremes I'm not sure how we recommend something that addresses those.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

My one thought that I would like to share is that it shouldn't be one size fits all, right? Some consumers will have different expectations and some disclosers may have to comply with different obligations and there has to be some way of differentiating those that can satisfy the requirements of the State of California or the VA versus those that can satisfy consumers who have more risk tolerance than others.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Yeah and I'll...so, first comment is, it's been clear for a while but now it's incontrovertible that we won't make it through these slides in the time that we have available and so I'm going to stop trying because

it's pretty clear we won't get there but we do have a number of other themes that we could touch on and maybe the best way to do it is by e-mail, but we'll come back to that.

On the subject of certification my sense is we need to make it...so my personal belief here and I'm, you know, I'm willing to be swayed otherwise, but my conviction right now is, we need to make it clear that certification is not a barrier to which Apps the patient can choose. So, whether an App has been "certified" or not a patient should be able to use the Apps they want. I think that comes straight out of the regulatory language or at least I hope it does.

And at the same time, we need to say that there are a lot of different reasons or different perspectives from which an App might be certified and maybe the best recommendation that we can make is to provide a consistent or standard way that different organizations can endorse the same Apps or certify the same Apps and then we get to have a number of viewpoints that are all overlaid on top of each other.

So, when a healthcare provider wants to make a decision they can choose the voices or the viewpoints that they trust the most in that crowd and say, well, we'll just trust the ones that we've decided align with our needs but different organizations might pick different subsets.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Hi, this is David Yak, could I just add a comment here?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Of course.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

There is a corollary here in the basic MU certification where there's an independent certification outlined by ONC for ePrescribing but yet there's a commercial certification that Surescripts conducts to permit, you know, transactions to be sent on the network and there was some confusion and/or disappointment I think on the part of the EMR vendors that they had to go through two certifications which were, you know, 98/99% identical.

So, I think we're dealing here though in a situation where there are no sort of bonafide, verified, commercial third-party certification of healthcare IT applications which could be then used as the proxy for ONC to say that there's, you know, a certification out there in the marketplace.

The same thing for consumers, there is nothing out there that they can turn to and say that there is an Apple iStore or a Google Play Store that is somehow, you know, curating and reviewing and approving applications so they're sort of on their own.

So, I mean, I think we may have a timing issue here and that there may be a set of recommendations we make now to be practical and then as the commercial market evolves and develops and there are bonafide or trusted sources that this may change the landscape.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

So, coming back to our agenda, leaving time for public comment at the end of the call, we have just four minutes. So, what I would like to do with these four minutes rather than pressing ahead through the themes is to talk just briefly about how we can take some of this conversation off line because we have only limited time for these calls.

I don't have all the answers on this one, but one thing that I think would be good to do would be to list out these themes in a place where we can have individual comments about them where we can share some discussion. So it could be as simple as an e-mail thread about each theme that somebody wants to further discuss and try to make the e-mail subjects match up with the slide headings that might be that sort of lowest tech way that we could go about it, but I'd be open to other thoughts or suggestions about how we could carry on this conversation between now and our next call.

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer – Walnut Hill Medical Center

This is Aaron Miri, I'm up for that. I'll e-mail, you know, you and you guys a couple of thoughts and concepts I think we need to further tease out especially as it relates to providers and liability considerations.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Thanks, Aaron. Other comments or thoughts on how we take this forward?

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Josh, I thought, you know, sort of your simplistic view of having an e-mail with each of the...content from each of these slides as, you know, a thread and, you know, ask the different advisory group members to comment or ask, you know, add to the content might be a way to extract a lot of data without a lot of effort from us.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Okay, so let me say this, I won't start any threads unless I personally have something to say about them, but what you should do, you members of the Task Force and me and Meg as well, is to read through these slides, especially ones we haven't addressed yet, but also the ones we have addressed, and if there is something that comes up where you want to make a comment or ask a question start a new thread for that and I think that's the lightest way that we can take this one forward.

Just a couple of quick comments, I'm going to jump to the end of the slide deck here, which is going through a couple of the preparations for our next meeting. We're going to get clarification from OCR as we mentioned earlier on today's call.

And there is a slide towards the very end that attempts to summarize some of the top challenges that we're facing and some of the drivers or key drivers for success and just to highlight these in terms of challenges and successes, I'll say, please look through these and consider whether there is any additional points that need to be made on the slide or any reframing of the way that these are currently listed, so think about that as well as you're going through the themes. So, with that let me turn it back...

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Yeah, this is Meg and Josh, I would add to that, in particular because we will have OCR for 45 minutes during our next call, take a peek at what has been carved out as questions that they've been asked to handle and as Linda mentioned if there are any other questions or any other areas that you'd like them to explore during that call, I think to make the best use of their time, if you could e-mail that ahead of time I'm sure they would appreciate that.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Perfect, thanks, so that's our last piece of homework is think about what we want to hear from OCR and share your thoughts. And thank you, Meg, I was going to turn back over to you before we open up in case you have any additional comments.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

No, Josh, thanks, great job, lots of information, I think we've got a lot of work cut out for us but some good resources to help us get through it. So, just a general thank you.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Excellent, all right, well let me turn over to Michelle and I think we have just enough time to open up for public comment.

Public Comment

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

Thanks, Josh. Jaclyn or Lonnie, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

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.

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

While we wait for those on the phone we did receive a comment through the public chat that we will e-mail around to the Task Force members. And it looks like we have no public comment. So, thank you, everyone we appreciate your time.

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

All right, thanks very much all.

David Yakimischak, MBA – Senior Vice President & Chief Quality Officer – Surescripts

Thank you.

Aaron Seib – Chief Executive Officer – National Association for Trusted Exchange (NATE)

Thank you, guys.

Meg Marshall, JD – Director, Government Health Policy – Cerner Corporation

Thank you.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks.

Public Comment Received During the Meeting

1. William F. Kinsley (NextGen): William F. Kinsley (NextGen Healthcare Info sys) If Dynamic registration of client applications is required; providers (API End Point Services) should have the ability to Black List and/or White List client applications (and users) to manage risk and to meet their legal (and ethical) responsibilities to provide privacy, availability and data integrity of the EHR information without risk of being of accused of “Data Blocking”.