HIT Policy Committee
Privacy & Security Tiger Team
Transcript
April 28, 2014

Presentation

Operator
All lines are bridged with the public.

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

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Hey, Deven. Micky Tripathi? Andrea Wilson? David Kotz?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
David McCallie? Dixie Baker?

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Dixie. Gayle Harrell? John Houston?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Hi, John. Judy Faulkner? Larry Garber?

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

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

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

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

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

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

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

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

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

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

Wes Rishel – Independent Consultant
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
And Kathryn Marchesini from ONC?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Are there any other ONC staff members on the line?

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Hi, this is Joy Pritts and –

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

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Hi, I also have with me the SAMSHA team.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Maureen Boyle.

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Okay, and with that, I'll turn it back to you Deven.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay, great. Thank you very much, Michelle, I appreciate it. So we're going to continue our discussion today, providing input on some recommendations that originated with the Certification and Adoption Workgroup regarding behavioral health and certified EHR technology. We had a great call less than two weeks ago, actually, where we heard some interesting presentations from a couple of the technology vendors who are in the process of implementing the technology standard for data segmentation, the data segmentation for privacy that initiated as part of ONCs S&I Framework. And we also heard from our own Dr. Larry Garber on how he handles behavioral health and the myriad of data that has – needs to be treated with special consideration under Massachusetts law, how he handles that today. And we also heard from a health information exchange.

And while we initially had teed up another health information exchange to kick off this call today, we made the judgment, Chair and Co-Chair, and speaking also with ONC that we probably, given that what we're deliberating here is really the issues involving certified EHR technology. That potentially hearing from another health information exchange dedicated to behavioral health, the exchange of behavioral health data, while certainly interesting and valuable, might not be as directly relevant to the set of issues that we're focusing on today, which does have to do with EHR certification. We certainly can, if you all disagree with me hear from folks at another time.

But we actually thought that the 90 minutes that we have for this call today might be better prioritized with talking to folks from the Substance Abuse and Mental Health Services Administration, SAMHSA, about some of the questions that arose during our previous call, about the scope of 42 CFR Part 2. And then spending some time sort of walking through what we learned in the meaning – in our last meeting and thinking through what kind of a response that we might have for the Health IT Policy Committee on that set of issues. So essentially the plan for today is to spend the first 20-25 minutes, ideally, getting some answers to questions from the SAMHSA folks who have been kind enough to join us on this call.

And then, walking through some straw slides that I developed for you for which they are not at all definitive. The purpose of doing the slides was to tee up the discussion and to get us talking, because we do have a slot on the Health IT Policy Committee agenda for next week, not to present final recommendations. Because I think, we're probably going to need a little bit more time, but to at least put in front of them some of the issues that we are deliberating, so that we can actually get some early feedback from them, also provide some very early feedback to the Certification and Adoption Workgroup. And hopefully be able to ideally wrap up all the issues related to the behavioral health recommendations by the June meeting. Does that make sense? Do folks have any questions about that?

Kitt Winter – Director, Health IT Program Office – Social Security Administration
This is Kitt. That sounds like a great approach. I just wanted to let you know that I am not going to be able to access the Adobe site, so if you can let us know where you are, I'd appreciate it.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay. Will do. All right, so with that, we're going to not be on the Adobe site at all right now, Kitt, so you're in luck. We're going to talk to the folks at SAMHSA about some of the questions that arose. And we teed up a couple of them early on, when we sent you all the copy of the transcript from our last meeting, we were also able to send you some – a response from Kate and Maureen to a couple of the questions that arose during the call. But there was a third question that after I had gone through the transcript, we realized had not been included on this piece of paper. And that was a question that was originally raised by David McCallie involving how does Part 2 deal with a situation where you have a healthcare provider – a non-behavioral health provider who gets a C-CDA from a behavioral health care provider that is covered – that has the restricted tag on it and the provider is able to view it. But then subsequently learns of the same information that would be in the C-CDA from a source that would not necessarily be covered under Part 2, so say it's another healthcare provider or maybe the provider walks through the information with the patient and reconfirms it separately with the patient. How is that handled under Part 2, how would SAMHSA view that?

So we let Kate and Maureen know that that question was coming, so I'm not blindsiding them with this, I hope. But then we have the other two questions for which they've provided written responses that were circulated to the Tiger Team, but for which there may be additional questions. So, before we jump into clarifications on the questions that we provided to you in advance, Kate and Maureen, I'm wondering if you would address the question that I just posed to you verbally, that came up on the last call, that we didn't get a chance to get you to write a response to in advance of this call.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Absolutely. This is Maureen and it's relatively simple. If you obtain the information from another source that's not covered by Part 2, then that information that you now have is not covered by Part 2 and can be shared. There have been kind of some discussions about whether – if you get information from a Part 2 program and have the patient review it, whether that now becomes your data that's not subject to Part 2, and we don't believe that to be the case. But in the instance where you're getting the information from another source, then that information is not covered by Part 2.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
So another source other than the patient.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Right.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
So if you, for example, have the patient in your office and actually explain to the patient, and we would like to be able to have this information be part of our EHR, so that we can treat you better subsequently. But in order for us to do that, you need to understand that once we sort of incorporate it into our EHR, then we can't guarantee that if it gets redisclosed outside of the organization, that it would – that we could prevent that from happening.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Right. No, I think you do get into some kind of tricky space here because I think there are instances where you would say, okay if you're doing a med reconciliation and you're asking a patient to tell you all the medications that they're on. And a patient lists to you buprenorphine, that patient is disclosing that to their primary care provider, that's not Part 2 information. But in an instance where you might say, print out their health record and say, do you verify this as being accurate, without – obviously we can't give directed federal – I'm sorry, legal advice and we'd have to go to our OGC for kind of explicit clearance on something like that. But I think in that type of instance where – that that would remain covered if you're kind of saying like verify your record from a Part 2 program.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Right, just a mere verification – one of the things that we might – I think there might be other Tiger Team members who have questions about this. But it occurs to me as you're providing this response, that it might be part of our recommendations to ask for additional guidance on the circumstances under which this information sort of reaffirm – not merely verify, but reprovided, re-provided either by the patient or by another provider, would not be covered under Part 2. And again, I think the object here is not necessarily to wiggle out of coverage of something that's important. But to clarify the circumstances under which a non-behavioral health care provider who's receiving information from a behavioral health care provider can get that information incorporated into the record in a way that makes it more useful on an ongoing basis, but without breaching any laws, of course, and ideally, with transparency to the patient about what's going on.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Right. And we'll be happy to reach out to our OGC. I think the one thing that we would just say is, and like you're saying is, we wouldn't be viewing something like this as a good way of going around Part 2, that there can be kind of instances where the patient is revealing to you information and then that information is not Part 2 protected. But that we wouldn't kind of advise that as a strategy of getting around the need to prevent redisclosure.

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
Deven, this is John Houston. I think the other – the practical concern that I think a lot of providers have, and I guess maybe it's assumed in this discussion is that, if we get information that...within a – outside of a substance abuse treatment program. And try to incorporate it into our medical record, it sometimes – well, it's difficult if not impossible, necessarily, to re-segregate that information or add the same restrictions on that information, especially if it's being digested into an EHR that's not set up the design to handle or to support substance abuse treatment programs.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
This is Larry Garber; I'd like to reinforce that. I mean, let's say I'm in Indiana where basically HIPAA is the law and I'm – a patient sits in front of me and tells me that they're on methadone in part of a drug treatment program. I put that in my record and I presumably can release that as part of treatment, payment and operations within Indiana, because that's what HIPAA permits. Is that correct?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
No. So 42 CFR Part 2 is a federal law, so both HIPAA and 42 CFR Part 2 apply in Indiana. And so if the information is subject to 42 CFR Part 2, in other words, if it's coming from a substance abuse treatment program that's federally funded –

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
No, no, it's not – no, I'm sorry, I'm just saying the patient sits – comes to my office and tells me this. I haven't gotten anything from the program. If the patient tells me they're on methadone and in a program, am I allowed to put it in my record and release it under HIPAA?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yes, absolutely.

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

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
It's – information that's covered is information that's coming directly from the program.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Exactly, so if the patient told me directly, then I can re-release it in Indiana as part of TPO.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yes.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
If I'm sitting in front of that same patient and I happen to also have a piece of paper from the treatment program that says that they're on methadone and in treatment program, and I discuss that same information with the patient, are you saying that I'm now not allowed to put that in my med list and release it?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
No, I think what we're saying was kind of explicitly in the example of you've asked a patient to tell you what medications they're on and they've just disclosed that to you. We're saying that it gets somewhat fuzzier when you're kind of looking at a whole patient's record – you have their whole Part 2 record, and that you can't just say, can you verify everything on this sheet and then integrate that into your record. But where the line kind of exactly goes, I think part of it goes back to what Deven was saying with – that if you explain to the patient your purpose and the fact that you're integrating it into your EHR so that you don't have to protect that information, then that may be one thing. But I think part of it is the patient fully understanding the implications of sharing that information with you.

Wes Rishel – Independent Consultant
This is Wes.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Go ahead Wes.

Wes Rishel – Independent Consultant
Deven, you used the formulation in this conversation that I thought was particularly helpful and I wanted to just make sure that I'm reading it properly. What you said was as a, and you described it as explaining to the patient the use of information. But the way I understood you to say it is, if it is received as SAMHSA information, we don't put in the medical record meaning, I think, that we don't – we may put the report in the electronic system that includes the medical record. And we may be able to maintain control over that so it's not re-released, but we don't extract the computable data and put it into the computable medical record and therefore have it available for clinical decision support and so forth.

And I think there is, at some levels of policy, there's a belief that EHRs should be able to track individual data elements that way, but the reality is, we're not there. So I wonder, can we just use that as our formulation, that in effect data received as part of a, in this case a CDA, which might be extractable, cannot be extracted into the medical record of a non-SAMHSA system.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Yeah, actually, so Wes, that was my impression from speaking to both of the vendors. Having gone back through the transcript and reread their presentations and their answers to some of our questions was that, when they would get the Part 2 restricted document that it would be view only. And that it could not be parsed or interdigitated, consumed, or pick your verb, by the certified EHR technology that would ordinarily, with any other document, be able to incorporate the data into the various parts of the EHR. So that's why I made that initial sort of posit –

Wes Rishel – Independent Consultant
Right.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
– about – we were.

Wes Rishel – Independent Consultant
Right. So I'm just suggesting that if we use that formulation as a basis for these discussions, because I think a lot of people on the Tiger Team are – have certainly been through this and understand the logic. But I think it's important to sort of dwell on the difference between accepting and sequestering a report and making it viewable to a physician and accepting data and integrating that into the computable data of the EHR. So I think – I just wanted to pick that point the way you said it and emphasize that as a way to go about talking about this.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Right, thank you Wes. It shows up in later slides, but we moved the SAMHSA discussion up first and I'm probably jumping ahead, I think that's important to emphasize. Thank you.

Wes Rishel – Independent Consultant
Thank you.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
And I would just say from SAMHSA's perspective that we think that that's a very good kind of interim solution. Like really where we want to get to is a place where electronic health records can receive Part 2 records and have a basic level of compliance with Part 2. So whether they're advanced and they can use metadata and integrate information or whether they're using a silo, we think either way would be a huge step forward right now. Okay.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
Could I ask just one clarification, Deven?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Of course, Dixie, go ahead.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
This is Dixie Baker and this came up during the testimony as well. I think some people interpret behavioral health as anything having to do with behavior and just to be absolutely clear, I think when we hear the term behavioral health with respect to segmenting data, we're talking only about data that come from a behavioral health program that operates under 42 CFR Part 2, is that right? We're not talking about some counselling that somebody received.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Well, that is the issue that's before the Tiger Team right now, Dixie, you're absolutely correct.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Yeah, that's correct. Although I do think, so one of the questions Dixie that was teed off of Larry Garber's presentation was whether if you're a general medical provider, but you have a DEA license to prescribe controlled substances. That DEA license comes with some commitment to abide by Part 2 for that data, which was part of the responses that we circulated to you. So Larry, even though you're response is a little perplexing to the rest of us, it turns out that I think you were correct. Although I want to give the SAMHSA folks an opportunity to try to clarify how someone with a DEA license, but whose primary function isn't providing alcohol and drug abuse treatment, but who might be prescribing something, as a general medical care provider to meet a need of the patient. Does Part 2 cover it nonetheless because the DEA license is involved?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
No, it's a combination of, well being federally assisted in some way, which a DEA license falls under that federal assistance, but they also have to hold themselves out as providing substance abuse treatment services. And so – and obviously that's a little bit of a fuzzy language, but if you're advertising, if you're – have staff who only provide substance abuse treatment services, things like that.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Oh, okay, so it's not everyone with a DEA license, it's DEA license plus holding yourself out as providing these types of services.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Exactly.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Well, this is Larry again. Thank you for that, I feel a little bit better about myself, but one of my colleagues sort of became – I'm from a group of physicians, there are 265 of us in our group practice. And so one of our physicians sort of became our specialist in this field, so that if we had patients who needed to go through alcohol withdrawal, instead of having to send them to one of the community programs. He was really good at this and he could manage their meds, and so internally, we knew he's the one to refer this patient to, just another internist. So within our group, he held himself out as the expert. This was never publically advertised or anything like that, just internally. Does that – is that considered a program that would fall under this?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
My understanding would be it would have to be a public – you publically would have to hold yourself out.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Whew, thank you. You should write that in the transcript.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
So now that we've made Larry happy –

W
The legal advice portion of the hearing –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
That is not official legal advice.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
No, it is not official, but it certainly is consistent with all of the guidance that I have read coming from SAMHSA.

Wes Rishel – Independent Consultant
And priceless.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
I'll sleep well tonight.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
This is Judy and I have a question about Surescripts. If information – tell me if this would happen, would information come from Surescripts that already has the patient prescription information on it, it combines information from different sources, including behavioral health and that gets sent to the EHR system by itself?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
I'm not sure I understood that last part where it gets sent –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
So the EHR systems may import Surescripts information to keep things up-to-date for the physicians.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
So I think there's a broader issue about prescribing and ePrescribing information that goes to a pharmacy or – and to Surescripts that is coming from a program. That's subject to these regulations that that goes – the protections do continue with the data and so if you have a prescription that's ePrescribed that goes to the pharmacy and to Surescripts, that that shouldn't be passed on to anyone else.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Right, but if it comes from an – a healthcare provider that isn't subject to Part 2 –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yeah, if it originated at the Part 2 program, then it would – the protections would follow. But if not, then –

W
There are no protections to –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Initially, yeah.

Wes Rishel – Independent Consultant
This is Wes. So let me pose a scenario here, which is admittedly worse case, but I don't think awfully unusual. A patient is in a Part 2 program and is prescribed a particular medicine for – by a physician in that program. The patient then sees another physician, the physician provides – prescribes a medicine that has a conflict with the medicine prescribed in the Part 2 program. The pharmacist, seeing this, is aware of the conflict and could call the physician and say there is – could he call the physician and say there is a potentially lethal conflict here, or would he be precluded from doing that because of the source of the information. And if the physician said, what is the conflict, could he tell them or not?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
So, I mean, this is not something that we have really addressed explicitly before that I know of.

Wes Rishel – Independent Consultant
Uh huh.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
I mean my gut reaction to that would be that they should call the patient and let them know, but I'm not sure – Kate, are you aware of this?

Kate Tipping, JD – Public Health Advisor, Substance Abuse and Mental Health Services Administration – U.S. Department of Health and Human Services
No.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
We can go to OGC with that question or Office of the General Counsel with that question.

Wes Rishel – Independent Consultant
Well I think – where I think primarily the focus for this discussion is as it relates back to Judy's question about what – I guess we must have to rely on Surescripts not to send this – to know that this is SAMHSA protected information and not – it, because if Larry's colleague prescribed the same drug, it wouldn't be SAMHSA protected.

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

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Right. So that is absolutely something that we're working to address right now is kind of those issues around Surescripts and pharmacies and them being aware of what information is protected and what their obligations are around that. You're right, in that context where the information is Part 2 protected, they'll need to know and have systems in place to prevent the information from being passed on without consent.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
And will Surescripts always know, so if a patient walks in with a paper prescription to hand to the pharmacist, is Surescripts –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
I don't know if you can do a controlled substance on paper. I don't think you can do that, Judy.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
I think you can, you can do that.

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

Wes Rishel – Independent Consultant
It's the only way.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
You can do it on paper and – well, anyway, there's that. And then the second thing as a follow up to Wes' concern about if the pharmacist sees that there's a contraindication, what if it's not the pharmacist? What if they're about to give something to a patient in an inpatient situation or an ED situation and the system, the computer knows it's a contraindication, what can the computer do that it is a possible fatal conflict?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
So as far as the paper prescription goes, if the patient is handing over the prescription themselves, then they're the ones giving the information so it's not protected. It's only in the ePrescribing scenario where the patient hasn't given their consent for the information to go past the pharmacy. In the context that you're talking about with the computer, I mean I think the same issues are in play, whether it's the computer or whether it's the pharmacist, and that's not something that we have gone into detail with. I mean I think right now what I would say is, if it requires consent to share the information and no consent is in place, that neither the computer nor the pharmacy can share that, in compliance with the regulations. There are medical emergency provisions, but we haven't really looked at that in the context of a potential interaction as opposed to a current immediate threat to the –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
The could I ask I think a very important question, which is, if this gets in place before that's resolved, we will knowingly kill people and I think the damage, not only to the person, but it's going to be a very bad situation. Is it that those evaluations can be done before this has to be put into place?

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
We'll address this as quickly as we can, but I'm not sure how this does that, because the regulations have been in place for a very long time, nothing that we're talking about here is any change to the regulation. This is just talking about increasing the sharing of information, so can you kind of walk us through how we're going to be –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Well, I'm not sure that it increases, if in fact what the EHRs have been doing is sharing all the information.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well, but if they have been, Judy, then presumably they've been doing so because they're not covered under Part 2.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Well I think –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Otherwise, they're breaking the law.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Yeah, I think the difference may be that many organizations will say to the patient, we need all your information, do you agree? And now I think what you want to do is allow them not to agree, and then we're going to be into a new situation with these.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Yeah, but Ju – but that's sort of taking the law and twisting it the other way, Judy, they've always been in the situation not to agree, so we're not changing that. In fact, if the information didn't have a way to move, it wasn't going anywhere. I think the issue that we're trying to address here.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yeah, I mean I agree with that, I think what we're – like right now what's happening is people are not exchanging Part 2 records and so the primary care provider doesn't have the list of medications from that organization. And now we're saying we want to set systems in place that allow for the sharing of information. There's – you'll never necessarily, I mean at this point, you won't necessarily ever have a complete record, you don't – so we have a lifetime record of a patient from all of their providers, you always have to assume that you don't necessarily have everything in your record.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Well, I agree and I don't agree, because I've asked a bunch of doctors exactly that, what if you knew that stuff was omitted from the record? And what the doctor says is basically, I wouldn't trust the record at all, I'd start from scratch, as if it didn't exist, which kind of messes up –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yeah, I mean –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
– the whole purpose of having the information. And another thing, if in fact that data didn't come before, now it's there now, now there's knowledge that both the pharmacist and the – if it's in that situation, or the computer system has, that it didn't have before, which is, the thing that you're going give to this patient is going to harm this patient terribly.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Okay.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Judy, I think we need to – you're essentially bringing up the policy issues and I think we've got – we need to – we will have time to discuss all these points that you're making, but I need to sort of set the stage for how we got to this place as opposed to using our SAMHSA time to begin this discussion.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Okay.

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

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
But I asked for cla – this is Dixie, for a clarification of what Maureen responded to Judy, about if a patient gives a paper prescription to a pharmacy, is – what I heard was that that implies that it's okay to share that with Surescripts. Is that right? Does that imply a consent to share it beyond the pharmacy or –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
So, it's not an implied consent, it's basically the information isn't protected because the patient is the one revealing it and not the Part 2 program. So –

W
So the Part 2 requirements would no longer apply.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
And a patient – does the patient have an opportunity at that point to say, I want this protected or –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Unfortunately no, the way the regulations are currently written, it's information that's coming directly from a Part 2 program that's covered. So if a patient hands over their own information, they don't have any right to protect it at that point, not through Part 2.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
So this is giving – electronic prescribing definitely is giving patients greater right to protection then.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yeah.

Wes Rishel – Independent Consultant
Another point is that most of Surescripts data comes from the PBMs rather than from the EHRs where the prescriptions are written. That is, the best of my knowledge, EHRs don't upload their medication list for a patient to Surescripts; they query Surescripts and find out the union of all pharmacy benefits paid claims. So –

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
That is cor – this is Larry, that is correct although they're starting to also do fills, not just the claims, but they're also starting to take it from the pharmacies.

Wes Rishel – Independent Consultant
Again, it's – the source of the data is, in effect, a claims system and it's not the SAMHSA provider, it's not another provider, it's the claims system and I just don't know what – how SAMHSA data is protected in a claims system.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
It's not because it's not coming from the Part 2 provider, I think that's the answer.

Wes Rishel – Independent Consultant
So the whole discussion, vis-à-vis Surescripts as opposed to using Surescripts as an example of a more general problem, but the whole discussion vis-à-vis Surescripts is kind of moot.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Yeah. Let's – I'm going to suggest just in the interest of time, that we try to move us through some of this introductory material and get back to sort of the nugget of what we've been beginning to talk about, which is good. It will all hopefully add up to some preliminary thoughts, not conclusions necessarily, at the end. And I just want to remind folks of the question that sort of brought us into this whole conversation, which is, a proposal from the Certification and Adoption Workgroup that there be various aspects to a voluntary certification program for the Part 2 behavioral health care providers. That would include some way to indicate that the data that they are sharing, because they are covered by Part 2, is covered by Part 2.

And what the Certification and Adoption Workgroup initially landed on was, well, if the behavioral health care providers are going to be sharing data outside of their walls, then the non-behavioral health care providers that are potentially going to receive that are going to need at least the capability to read that data. And so that's really what brought us to this – oops, sorry, didn't mean to go too fast – brought us to this set of discussions. And so in sort of preparing both for this call but also with an eye towards where we might be sort of presenting this material to the Policy Committee, we sort of start by reminding the Policy Committee of where the committee has been before on these issues. Which is work that the Tiger Team did when we very first were formed back in 2010, in terms of urging pilots for this type of technology, but sort of understanding that there are lots of issues here.

Then what I did in preparation for this call, and again also subsequent calls was to say look, we're coming to these issues again with a similar level of policy angst. And I think we heard that reflected both in Larry's presentation from a couple of weeks ago, but also in the comments of Judy right now that there are a lot of difficult issues to consider around here. And that while having information from behavioral health care providers is important for coordination, the presence of consent requirements, while being important for patients, also creates a great deal of concern among providers, who want to provide the best care for their patients. But have concerns both respect to their own professional obligations as well as potential liability about incomplete, and Larry you'll see I used your term here, Swiss cheese records – I'm so sorry Kitt, we're on slide 6.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
I'm honored, thank you.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
But acknowledging that again, it's not new, as Kate and Maureen from SAMHSA said it's not new to say that providers are needing to act on incomplete information. But you do get the sense that when you're using an electronic health record, there could be heightened expectations of having more complete information. And not sort of knowing even when things – when information is missing, when you're looking at an EHR, is a new dynamic that is arguably different from paper.

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

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
This is Larry. I have – there's really another point here. So it's not just the liability issue, which the Swiss cheese is important, but the other is, in order – my understanding is that if I do receive information from an Part 2 provider, I am allowed to redisclose it with the patient's consent, right, or not disclose it if I can't get the patient's consent. And in order to get the patient's authorization for that, I have to give informed consent and that implies that I have to be able to explain to the patient the risks and benefits and alternatives for what happens if this information isn't included and I send this Swiss cheese record to somebody else. And the reality is that none of us can really predict what harm – what preventable harm or even death may occur to this patient by not disclosing this information to the next provider of care. And so if I don't understand what the risk is, how can I properly convey that to the patient and get an informed consent from them?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Right, that's a good point.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
Yeah, but – this is Maureen, and I would say at the same time that statutorily and regulatorily the patient does have the right to withhold their whole record if they don't want to share it. As well as we ultimately want to get them to kind of the more meaningful choices of being able to share part, if they're truly uncomfortable with sharing some sub-elements of their record. But if they withhold their whole record, you still have a Swiss cheese record, because you still don't know what happened in that facility.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay, thank you – thanks to both of you, want to sort of make sure we get through to the nut of what we wanted to try to discuss here. I'm going to, again, some of these are introductory slides and so where I am is actually on slide 9, which is essentially really, what I want to spend the rest of our time discussing here. And I framed this as sort of what we – both a few slides on what we learned from our exploration of this issue. But then I did pose some straw recommendations for your discussion, and there are a couple of those slides.

So essentially working through the ones on slide 9, and I'm going ask you all to sort of hang in with me a little bit until we get to the straw recommendations. Because I'm happy for you to sort of pick apart wording and provide me with some feedback on points – things we learned that I missed, or if you completely disagree that we learned something out of this process, I'm happy to have pushback on that. But this is all really introductory material leading to recommendations, and I do want to make sure we get to the recommendations, so if you'll just sort of bear with me a little bit, make a note where you want to make a point, and then let's get to the straw recommendations part and have a collective, meaty discussion of all of this.

So again, certainly in the paper world, and we learned this from Larry, really the way we handled sensitive information like this was to try to redact it, by hand. And this was a less than perfect solution because there were inferences one could make from data that was left in, and leakage of data was still possible, for example, data in notes or information in physician's notes that revealed something that had been omitted from say a lab test result, for example. And some health information exchanges, we know this actually not just from what we heard a couple of weeks ago, but what we have heard over the course of any work that we've done where we've queried state H – or we've asked questions of state HIEs. And pr – that they won't accept information frequently from Part 2 providers or programs because of this additional constraints on that data, but certainly some private HIEs have been established, which we heard. Provi – behavioral health care providers, the Part 2 provider is the one who is required to get the initial authorization from the patient to disclose the information to another care provider.

What we learned from the technology, we saw is that the C-CDA or if in fact it is an individually disclosed data element that is shared, that it is at this point most often in the complete C-CDA. Coming from the behavioral Part 2 health provider as tagged either in the payload or the metadata with an indication that the document is restricted and cannot be redisclosed without further authorization. And then on the recipient side that provider has the capability to view the restricted C-CDA, or in the case of a shared data element, that data element. But that data then cannot be, and here's Wes, parsed, consumed, interdigitated, we can pick our favorite verb, into the EHR because doing so would risk the possibility of redisclosing restricted data without subsequent authorization, and providers who are not using this technology, could not even actually view the information. So in some respects the technology does need to be present on both sides in order to at least enable to the data to be read.

We also learned that the implementation to date has largely been either "all in" or "all out" with respect to the disclosure of information, again from the Part 2 providers or programs. And that the restriction tag applies to the entire document. And that one might be able to achieve granularity by not putting the information in the C-CDA at all, but this of course raises the Swiss cheese problem that we just talked about, and the providers would not, in fact, even know that the data were missing. And so we also learned that there are some next steps for the technology companies who are working on this, and that includes enabling some query of behavioral health providers, so it's not just, forgive me to the technology experts on the phone, the "push" but it's also the "pull." And enabling decision support without risking unauthorized redisclosure and enabling this parsing, and maybe that's saying the same thing twice.

So when I got to the part about sort of teeing up some recommendations for you all to consider, here is what I'm initially proposing, absolutely subject for discussion. It's really aimed at getting this discussion started, which is to admit right off the bat this is far from a perfect solution, but that it could be the on-ramp or the first step to enable the sharing of the information by these Part 2 providers. Again, they're the only ones that are covered under this, with the other providers who are caring for those patients and certainly while view only is less than ideal, if today this information isn't being disclosed at all. Because of concerns around legal obligations and the behavioral health providers not having a way to exchange the data, subject to restrictions, it may be better than nothing, especially if the providers who are receiving it feel – have the sense that having the ability to at least see the data is better than having nothing at all.

And of course, the sense that you either have to share it all or share none of it, the all or nothing approach, is always less than ideal. But it certainly provides one way for the information to be disclosed from a behavioral health provider, when the patient's provide authorization, which we understand occurs the large majority of the time. Based on what we heard both in the presentations, but also going all the way back to our very initial look at this in our data segmentation hearing of 2010, where we got the – essentially the same testimony from the providers at that time, and that was reflected in our recommendation letter.

So what are certification – what certification would potentially do is to at least enable the technical capability to share. And so that begs the question of whether, in fact, it should be mandatory for this to be part of certification in the EHRs, both certified EHRs as well as the voluntary program for behavioral health providers, so it's covered under Part 2. This would enable the functionality for exchange to be present, but would also create a way for providers who are reluctant to accept this data at all, for all of the downsides that we were talking about, that there would not be a concomitant requirement to use it. So in other words, no Meaningful Use requirement to accept behavioral health data necessarily, but of course having it in certification leaves open the option for menu for eligible providers and eligible hospitals. Or making the receipt of data from behavioral health for providers eligible to count for meeting information exchange requirements.

I suspect that I have not at all – this recommendation is definitely geared towards heading in the direction of where the Certification and Adoption Workgroup is going. And so I'm eager to get feedback on whether – how – your comfort level there and what your concerns are, as well as feedback on sort of the observations and what we want to communicate to the Policy Committee initially, as we start to engage them on this set of issues.

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

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

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
I think this is really good and I have one question that maybe a little bit of a nit that I – but I think it's important to move this type of thing forward, and it's on this actual slide. If we do certification of EHRs for this capability, I think the one thing that I think is also important to do is almost as part of the transport capability that there almost has to be a request or some way for an EHR in practice to be able to say, hey, I am DS4P certified. So that the EHR that's sending information or a HIE that's sending information to that EHR or to another HIE that has an EHR, knows whether that recipient has the capability to consume it in a way – that it has the functional – this capability to consume it and handle it and understand that its behavioral health or substance abuse information.

Wes Rishel – Independent Consultant
This is Wes –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well, they can't consume it, John, because the technology doesn't allow that, at least for DS – what we saw from the providers. But it would be an indication that they can at least read it.

Wes Rishel – Independent Consultant
This is Wes. I interpret John – I want to say what I think I heard John say and then say what I think about that.

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

Wes Rishel – Independent Consultant
I think I heard him say that there should be a way for the sender to know whether the receiver recognizes the DS4P flag or not.

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

Wes Rishel – Independent Consultant
And has whatever functionality is certified for reacting for the behavior in the presence of that flag. I have to say that that is the ability to dynamically, electronically negotiate characteristics of the interface is a great, great big can of worms and I would suggest leaving that to the agreements among trading partners or among HIEs, at least for this go round of regulation.

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

Wes Rishel – Independent Consultant
And then I have another –

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

Wes Rishel – Independent Consultant
Go ahead.

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
I mean, I understand it's a can of worms, my concern is that a lot of the send – that the entities that would want to send data would feel much more comfortable sending data if they knew that this certification was –

Wes Rishel – Independent Consultant
Well, and I'm saying the only practical way for them to know is externally through an agreement involving participation in the HIE or a bilateral agreement between the sender and the receiver for this round of regulation.

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
That's going to be pr – I mean, I understand that, but I think with – if you think of this nation as being a fabric and we can be sending to anybody at any time potentially at some point in the very near future. I'm not sure how we do that –

Wes Rishel – Independent Consultant
I think the – there are plans for a much broader look at the issues of sharing information in the information and that's a really appropriate thing to be continued. I have to say that if we were to go forward with the recommendation that this be an automatic feature of EHRs, I would dissent. I just don't think it's practical, in the timeframe for regulations that would have to be implemented in 2017.

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

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

Wes Rishel – Independent Consultant
Now, the other question I have, Deven, is that is there any thought to the necessity for a safe harbor for the receiving organization for not using information in a sequestered Part 2 document? So we say, on the one hand that we expect the EHR to be able to receive it, file it with the appropriate access controls so someone can read it, but not include it in its database so that the interdigitated into its database so that it can be recognized with a clinical decision alert. What – there's going to be an issue inevitably of a liability suit, a tort, involving failure to take that information into account, because it was there, regardless of why didn't the physician go look it up before writing every prescription, why doesn't the physician look up to see if there's any of this sequestered information. So is there any concern, do we need to raise any concern about a safe harbor for treating data this way?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well, that's an interesting point, Wes and I think that I – either we as a committee nor ONC as our direct report, has any capability to grant that. And so in recognition that we couldn't control that, my initial thoughts in pulling these slides together was to say, look we won't require providers to accept this data, we'll just give them the capability to do so if – are willing and desirous –

Wes Rishel – Independent Consultant
Yeah.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
– of keeping this information under the terms offered, which is, view only, no interdigitating and then –

Wes Rishel – Independent Consultant
Thank you ma'am, you are way ahead of me.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well, that's how I sort of thought to impose those controls, which is to say –

Wes Rishel – Independent Consultant
Yeah, no, that's great.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
– functionality is there, you don't have to use it if –

Wes Rishel – Independent Consultant
That's great. Thanks.

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

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
This is Judy –

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
I'd like to add one thing on that – this is Dixie, is I think it would be reasonable to ha – to require that the EHRs at least have an indication that there's additional information available.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Like what do you mean Dixie?

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
Well, if they're looking at a view of an EHR, that is mostly data elements, except for the physician's notes, and in another part of the EHR, they've got a PDF of this C-CDA that comes in, or whatever, but it's sequestered. It seems like there should be some indication to the provider that such a sequestered document exists, so that they would have the opportunity to go and look at it, if it – because it won't appear in the normal view of the record.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
That would be good if –

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

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
This is Judy. That would be good if there weren't many of these, but if a lot of them had these and there were numerous ones of these, and it wasn't well organized so that they could go through them easily, it would be – in other words, discrete, so you have all the meds together, it's going to be a big burden.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
This is Larry. I'd add to that that there's also, this stuff gets stale, so 10 years from now, when there's a note 10 years ago that was filed in this sequestered section, am I still going to be getting alerts to go ahead and take a look at that, and how do you decide when to stop showing that alert?

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
Well, that's in the details. I mean the alert could say the date or "in the last 6 months," or – but it seems to me that if the document comes over and is sequestered and buried in some part of the – you don't want the provider to have to go there every single patient that comes through. It would be – I think it would be convenient for them to know when a patient had some more information in document form that they should go and look at.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
So do we, I mean, that's – I think we can go back and ask the vendors from the pilot. That question didn't come up, as I recall, from – but we can ask them sort of how the sort of notification that one of those documents has come in. But it also occurred to me, in the sort of line of discussion that Wes and I were just going back and forth on. If you in fact wanted the stop sign at the door like to make sure that you didn't have a document in your files that you never wanted in the first place – I mean there's hope that most providers will want to at least read the documents. But if there are some who really are not comfortable with it for all the reasons we discussed, how do you put the stop sign and/or, per John Houston's indication, like a notification like we're not open for business.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Deven, this is Joy. If you – I don't know if anybody has seen the demonstration by Netsmart, I always say the wrong thing – by Netsmart. But I believe on their system that before anybody opens the document, they're given notice that this is a 42 CFR Part 2 related material and if you're not willing to accept the terms, you decline right there and nobo – it never gets into your system.

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

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Right, but the person who sent it thought that it got to you.

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

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Probably, I don't – again, you'd have to ask whether it bounces, I don't know that last piece.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Would there be li – would there be liability for not accepting it if you – if there was contraindication information in it?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
It's hard to say, Judy.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
I'm just – I kind of – never mind.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
This is Larry. There's another point here which is, when I receive documents, I generally will summarize them one way or another, if I get a CT report, I will write somewhere the essence of what that found so that each time I don't have to go read the whole thing, I now know what the gist of this document is. And so if we were to go through this process where I can view it, but I can't abstract it into my record in any way. There would – ought to be some way that EHRs allow me to tag – right some summary, some note that attaches to it that says, okay this is the summary of what this tells me and I don't have to read the 10 pages every single time.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
And would that abstract then be protected under Part 2?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Yeah, apparently unless I'm sitting there talking to the patient, then I can stick it in where I want. But – which is also silly, but that's another story.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Larry, isn't another point that if anybody else following you with care of the patient wants to know why you made what may appear to be a very strange decision, you need to put that into your notes so it can make sense to them what you're doing for that patient.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
That's exactly right.

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

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
And now the other thi –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Sorry, go ahead.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
This is Larry again. One more thing, when we talked about the pilots, my understanding was that one of the pilots was still completely in a test mode, that they hadn't actually done this with real patients yet, is that correct?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Yeah, but I thought the Netsmart – that was SATVA, I thought Netsmart was in operation and in fact, we did actually try to see if we could get any of the non-behavioral health recipients of the restricted C-CDAs under Netsmart to be able to come – just call and talk to folks. And we just were not able to do so, given the tight timeframe between our last call and this call, but we can still try to that.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Because my feeling is that there are huge issues and implications with all the stuff, we're talking about and it seems like this deserves a much larger set of pilots than we're dealing with, with multiple different EHR vendors and complete evaluation. I would just be hesitant to make a recommendation that's going to have such a huge impact on our country, without having done enough due diligence.

Wes Rishel – Independent Consultant
This is Wes; I'd like to suggest that Deven's proposed approach effectively allows for that piloting, in the sense that nobody's obligated to receive these.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
But aren't we suggesting EHR vendors are going to be putting in functionality?

Wes Rishel – Independent Consultant
Well, we – we're suggesting that they would have to be certified for the functionality and that someone then who wanted to run a pilot would have the ability to do it.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
But shouldn't we be making sure that it was tested and vetted before we ask EHR vendors to start considering putting this functionality into their systems?

Wes Rishel – Independent Consultant
Umm, that's a reasonable point to make. I'm just suggesting that – well, I have to – that's one of the questions that's on balance, and I'd have to think about the balance of – it seems to me that there are probably situations where the proposed approach is clearly appropriate. And I don't know how to – I mean, how would you – let me just say I don't know the answer to your question.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
I don't know it either, Larry and I actually am – think that it is a question that is worth par – spending some of the time that we have with the Policy Committee next week exploring this further. Because it was our recommendation back in August of 2010 that these technologies were – really needed to be piloted and that ONC should make it a priority to test them. And in fact they did that, through the S&I Framework and we were able to hear from both an implementation still in pilot phase, but also one that is out of pilot phase and currently being utilized, as well as a private behavioral health HIE that we heard from as well. And so it raises bigger questions, I think, about sort of how mature does a standard have to be for certification in EHRs, especially if it's not going to be tied to a mandatory requirement to use? And so I would like to get more feedback from folks on it.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
We've developed those metrics in the Standards Committee that we currently use to judge a readiness to become a national standard, and I was going to interject this that what would come – the Policy Committee isn't responsible for deciding whether a standard is ready for primetime, that's a Standards Committee responsibility. And if this recommendation came over from the Policy Committee to – then it would go through the same metrics that the Standards Committee puts everything through.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Having spoken to some of the Standards Committee, they question why the Policy Committee sends them certain –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay, well, so what – so this is coming out of a policy – another Policy Committee workgroup, Certification/Adoption, which was actually tasked to look into a voluntary certification program for behavioral health providers. And they were the initial ones to recommend that the privacy standards developed out of the S&I Framework for behavioral health providers, to enable them to at least disclose protected data to another healthcare provider that those standards ought to be present in the recipients EHR technology so that the information could at least cross hands one time.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
And I would argue that that's a Standards Committee – the standards piece of it, not the functionality part. I would argue that the functionality, because that generally comes out of the Meaningful Use things, whether an EHR – a certified EHR would have to me – have to have a particular functionality would be a recommendation of the Policy Committee. But the standards part is – should go through the same semi-rigorous – at least semi-rigorous process that we do for other standards, to determine whether they're ready to become a standard.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Right. So that means that our job is to determine whether it's desirable to have this functionality, not the readiness of the standard for certification.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
That's what I would argue, yeah.

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Can I ask another – this is Larry, can I ask another question then about workflow and policy kind of stuff?

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Okay, so in the paper world, before I got all my discharge summaries electronically, there was one of the hospitals in my community that every discharge summary would be not for re-disclosure. They would just, every single discharge summary, no matter what the patient was in for, hernia, appendix, whatever, would have that stamp on it and that was not legal for them to do that because the fact is, that was making decisions on it, there was nothing that was statutorily protected in the information they were sending to me. And so we actually did re-release it. Now we're creating an electronic version where if electronic health records that are used by these SAMHSA programs is presumably the same EHRs that I'm using and my colleagues and other provider organizations are using. That they'll have this functionality where they can stamp a document and say, you can't redisclose this and – even if it's not a Part 2 document, right, it'll be EHR functionality. So now I'm going to be potentially receiving a document that, and I can't – that's not Part 2, and I won't be able to redisclose it because that's baked into the functionality of the EHRs.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Ah, okay. Well one thing that I think, I hadn't thought about that, Larry, in part because I was making – I was drawing – I was assuming that what would be certified into recipient, non-behavioral health EHRs would be the capability to view, not the capability to create documents that they would then restrict. Yeah, and I would also –

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Right, but we're all using the same EHRs, potentially.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well, right, and of course, you also have sort of programs that are Part 2 programs within larger facilities that are not necessarily all subject to Part 2. So, that is a question to sort of – that's a concern that we need to sort of track down and sort of see – maybe get some more feedback from the technology providers about what this – what they're saying, right. Are we creating this odd capability where somebody's going to do what you said, Larry, which is to stamp all their documents as non-consumable versus just having a mechanism for enabling that Part 2 covered data to move from point A to point B and at least be read.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Deven, I have another question for you, which is, does it have to be that this is the default way every patients' information is handled, or can it be that the default is that it can be redisclosed, given all the discussion we've had, but that a patient can request not to redisclose?

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Judy, there is a statute and a set of regulations that have been in place for decades at this point that say that a patient who receives care at one of these facilities, that is a treatment facility that is funded by the federal government. That their information is not disclosable for treatment purposes or many other purposes without the express consent of the patient and that when that information is transmitted to somebody with the patient's consent, that protection follows the information. And that's a statute and that is not going to be easily changed anytime soon.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Okay.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
And so –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
If the patient is going to behavioral health that isn't one of those, then there are no restrictions, is that correct?

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Correct. Well, there may be state restrictions, but there are no federal restrictions, yeah.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Okay.

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
Yeah I think, at least in some states, Judy, this is John Houston, those types of laws are typically interpreted to mean that consent has to be provided on a transaction or on a release-by-release basis, so you can't have any type of standing consent that –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Okay.

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
– permit somebody to have all of their information disclosed in every case. So we always look at is being a tra – sort of again, on a release-by-release basis, it has to be approved.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Okay.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Well, that's not necessarily true for all states. I mean, in Massachusetts, I don't have to do a release-by-release consent, except for HIV, which does have to be a get a consent for each specific release.

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
No, I agree, it is state specific, but I know like at least in Pennsylvania, we look at that from – for psych data and other types of data; it has to be on a release-by-release basis.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay, so we have a number of questions to clarify with the vendors, but we also have the capability to talk to the Policy Committee, even as we're sort of talking to them about what discussions that we've had to date, to raise these issues with them as well. Again, because what we're seeking is not to try to wrap this all up with a bow today, but to at least get thoughts out on the table that we can share with the Policy Committee and get their feedback. And also with the Certification and Adoption Workgroup, who is working on other aspects of this, so that we can ideally come to some conclusions in June and all of this is incredibly good set of questions. One other thing that I didn't – that we had a discussion about earlier in the call, but which I didn't reflect in recommendations on the fly is whether part of recommendation should ask for further guidance from SAMHSA about how these recipients will handle information that comes in from a behavioral health care provider with a restricted tag on it. And what are the ways that providers can work with patients in order to get their comfort level with having the data interdigitated into the EHR.

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

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
I have a question around that, Deven. This is Dixie Baker. Can a behavioral health provider obtain consent from the individual to allow their Part 2 record be sent to their provider and combined with their EHR data? Or is it by default, regardless of what the patient thinks, when you get data from a Part 2 provider, it must be segmented out?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well so I'll try to answer and Mau – thankfully we have Maureen and Kate on the phone, in case I screw this up. But my interpretation has been the data that's coming from a Part 2 covered program, that has the potential to – that either identifies or has the potential to identify the person as someone who is – has been receiving substance abuse treatment, that that data is covered under Part 2. And so that's the reason why the approach to sort of restrict the C-CDA that comes from that facility to allow it to be known that the data has the consent or the authorization of the patient, to be shared for that initial disclosure, but that it's subject to redisclosure provisions that Joy was just talking about. And you can't – and the disclosure – the authorization requirements in Part 2 are fairly specific, you can't do a general – it's okay to disclose to this provider and anybody that that provider discloses from that point forward.

So that's the reason why we went through this sort of set of questions at the beginning about what if the per – what if the patient reveals the information to the provider. Or what if – or are there ways for the provider to talk to the patient and get their consent essentially for redisclosure involving actually allowing the EHR to actually consume the data and allow the data to be used for medication reconciliation and for other aspects of an EHR that essentially take apart the CCD and just disperse the – make the tag less relevant. Does that make sense? You can't do all the consent up front.

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics
This is Leslie Francis, could I just throw in one other question that I'd like to make sure people address which is, what if a provider says to a patient, I don't think I can treat you unless you let me put the information from the SAMHSA record in your EHR.

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

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

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
But that's not coercion, though.

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

John Houston, JD – Vice President – University of Pittsburgh Medical Center; National Committee on Vital & Health Statistics
I mean, if a provider doesn't think they can care for you adequately because of information not the record, the patient still has the right to go somewhere else, don't they?

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics
Well, but suppose that it's going to be refused there? I just want that question asked.

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
That's a great question.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
Asked of whom, Leslie? You want it asked of the SAMHSA folks?

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics
Well I want to know what the SAMHSA folks think because my worry is that – I mean, the right is essentially ineffective if people get told everywhere that if you don't want this in the record, we're not going to treat you.

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

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Deven, this is Larry. Well I mean, that's a great point, but I'm wondering, Dixie brought up the point that we can't make decisions about whether a standard is mature enough, but we can make decisions about whether the workflows are understood well enough to move forward. So we could potentially recommend that there are enough questions with workflows that we would want to see more pilots.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
And who's going to fund those?

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

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
So that's one – I mean, what I'm sort of getting, again, I'm not going to poll the group, but number one, I want to go back – I want to put your question on hold for a second, Larry, because I want to see if SAMHSA has a response to Leslie, because that's a different question.

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
We'll get back to you more explicitly. I mean, I know that in – I know we've seen a lot of consent forms that basically say, you can't withhold treatment because a patient won't sign consent, but I don't think that's an explicit requirement of Part 2.

Kate Tipping, JD – Public Health Advisor, Substance Abuse and Mental Health Services Administration – U.S. Department of Health and Human Services
Yeah, and I mean, that's not something that Part 2 has been created to –

Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration
But it's also not something that we've seen, and granted this is relatively new. But I mean I like the concept of what you were kind of talking about before where because this is not a requirement, in some ways this is a slow roll out, because they don't have to do this. And so this will be – these are the same type of issues that you would have in a paper world, so the issues aren't new, it's a question of whether we see an increase in them because we're moving to the digital context.

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

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics
Yup, that's why I asked the question.

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

Leslie Francis, JD, PhD – University of Utah School of Medicine – National Committee on Vital and Health Statistics
That's all.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay. Thank you. So Larry, back to your question, I mean it wasn't my initial sense that I would sort of poll the group as to whether they were sort of thumbs up, we should – at this particular stage, thumbs up we should move this forward as a functionality that should be in EHRs or no, we need more pilots. I think what I was – although if folks from the group sort of feel ready to take that poll, I'm happy to do it. My sense was that I would report to the Policy Committee that there were some who thought we wer – that this a functionality that had been sufficiently piloted, that it's a functionality that ought to be in EHRs, leaving to Standards Committee whether the particular standard on the table is mature enough for certification requirements.

But it sounds like there are at least a couple of people on the call who think we haven't sort of worked this through enough from a workflow problem to even have the functionality be part of EHRs and that we still should remain in the pilot phase. Do other folks feel prepared to opine on this at this stage or would folks prefer to sort of wait until we get some feedback from the bigger Policy Committee? I'm fine either way. It sort of feels like it's the penultimate question, given how this question came to us initially.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
This is Larry, I personally feel that we've raised quite a few more questions and that I – my own personal opinion is that I'm not ready to say that – to recommend this without more piloting to understand the workflow implications.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
Is that from both ends, because the question that was posed to this workgroup was two-fold? One was the certification criteria for potential behave – voluntary behavioral health EHRs, and the second part was the EHR certification.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
So I'd say for both because I think they're tied.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Are there others who sort of feel comfortable? I know Wes, we heard from you earlier that, I don't want to put you on the spot, you're also free to say I'd like to hold off until the next call, when we hear from what the feedback from the Policy Committee.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
So what feedback exactly would you expect from them?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Well, I suspect it'll be similar, right, so keeping in mind that we as the Tiger Team, when we are able to come to consensus on something, I think that even in those cases when we present things to the Policy Committee, often someone will think of something that we hadn't thought of. Or ask us to consider a set of issues from another angle or push back a little on one piece of it, which causes us to sort think again about where we've come and in other circumst – but I guess I'm just saying that given that we haven't had a lot of time to debate this issue. But we have been asked for an initial sort of report on how we're doing on this issue.

It's an opportunity to get that kind of feedback that we normally don't get until after we think we're done, a little bit earlier in the process and it gives us an opportunity to sort of be up front with some of the questions that have come up. Even while we try to get some of them answered, some of the more technical questions that have come up, which we will get answered, probably not before the Policy Committee call frankly, but by the time of our next Tiger Team call. But it just enables us to get some early feedback on some of these same questions that we are grappling with.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates
I think that's a good idea.

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

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay. All right, we'll, I'm also looking at the clock and realizing that I have eaten considerably into our public comment time.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Deve – .

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
So that is the way that we will proceed, we will put before the Policy Committee this sort of very rich, but hard set of discussions that we've been having, and get their feedback and come right back to this on our next Tiger Team call. And maybe, ideally, even get some more feedback from the technology vendors on some of the technical stuff.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
This is Judy, as a technology vendor, I think the vendors would appreciate a number of those questions that are still up in the air being answered, in order to be able to develop the systems appropriately.

Public Comment

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Yeah, I hear you, Judy. Agree. Thank you. All right Michelle, we are so late, I'm sorry, but you can open us up for public comment.

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

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology
Okay. Thank you all very much. We'll be back to this issue next time and with more input from the Policy Committee for us to chew on. Thank you all very, very much, appreciate your participation and diligence on this.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Thanks a lot.

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

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
Bye.

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

Public Comment Received

1. Under 42 CFR Part 2 there would be no disclosure allowed unless it was Internal Communications
2. The regs at 42 CFR Part 2.12(c)(3)