



**HIT Policy Committee
Privacy & Security Workgroup
Final Transcript
February 23, 2015**

Presentation

Operator

All lines are bridged with the public.

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

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

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Here.

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

Hi, Deven. Stan Crosley?

Stanley Crosley, JD –Director, Indiana University Center for Law, Ethics and Applied Research (CLEAR) in Health Information; Drinker Biddle & Reath, LLP

Here.

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

Hi, Stan.

Stanley Crosley, JD –Director, Indiana University Center for Law, Ethics and Applied Research (CLEAR) in Health Information; Drinker Biddle & Reath, LLP

Hello.

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

Adrienne Ficchi? Bakul Patel? Cora Tung Han? David Kotz? David McCallie?

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

Here.

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

Hi, David.

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Donna Cryer? Gayle Harrell? Gil Kuperman?

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Gil. Gwynne Jenkins? John Wilbanks? Kitt Winter?

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Kitt. Kristen Anderson?

Kristen Anderson, JD, MPP – Staff Attorney, Division of Privacy & Identity Protection – Federal Trade Commission
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Kristen. Linda Kloss?

Linda Kloss, RHIA, CAE, FAHIMA – President – Kloss Strategic Advisors, Ltd.
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Linda. Linda Sanches?

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Office for Civil Rights
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Linda. Manuj Lal?

Manuj Lal, JD – General Counsel, Corporate Secretary & Chief Privacy/Information Security Officer – PatientPoint Enterprise
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Micky Tripathi? Stephania Griffen?

Stephania Griffin, JD, RHIA, CIPP, CIPP/G – Director, Information Access & Privacy Office – Veterans Health Administration
I'm here.

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

Hi. And Taha Kass-Hout?

Taha A. Kass-Hout, MD, MS – Director, FDA Office of Informatics and Technology Innovation – Food and Drug Administration

Here.

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

Hello. And from ONC, do we also have Lucia Savage?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Here.

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

Hi, Lucia. Kathryn Marchesini?

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

Here.

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

Is Helen on?

Helen Canton-Peters, MSN, RN – Office of Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Here.

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

Hi, Helen. Anyone else from ONC on the line? Okay with that, I will turn it over to Deven and Stan. I'll just ask for all you folks on the phone if you could please mute your line if you are not speaking.

Donna R. Cryer, JD – Principal – CryerHealth, LLC

Before you mute, this is Donna Cryer, I'm also in attendance.

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

Thank you.

Donna R. Cryer, JD – Principal – CryerHealth, LLC

Thank you, okay. Now you can mute.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Thanks, Donna. Thanks to everyone. Today we are taking a bit of a right turn from where we have been as a workgroup so that we can take up comments on the draft interoperability roadmap that was released by the Office of the National Coordinator just a week or two ago. Next slide, please.

So just to give you a sense of sort of where we've been and where we're going; we've been doing big data and privacy and we will continue to do so after we finish up our work on this interoperability roadmap. And we may, in fact, by email send you periodic drafts of some materials to get some early thinking on in advance of the next time we're able to turn to this topic. But we really do need to focus our attention on the interoperability roadmap. Now a number of you may have been present, or listening on the phone, for when this draft roadmap was unveiled by ONC at the joint Health IT Policy and Standards Committee last week. But, we're presuming that many of you are unfamiliar with it; it has a lot of aspects to it, but there are some very specific provisions that deal with privacy and security policy that we have been asked to provide feedback on by ONC.

And so in order to try to best prepare you to provide that feedback, and we don't have a lot of time to do...to provide feedback on this. We need to be able to report out at the April Health IT Policy Committee meeting and so we've essentially got today's meeting and also one in March, in order to process this. So we need to move quickly on a somewhat challenging topic, but I'm optimistic that we can provide ONC with the kind of feedback that it needs on the questions that they've asked us. But I think it really will be helpful for folks to see...to get a sense of what's in the roadmap, particularly relevant to the sections that we'll be taking up.

So I think this is the point where I'm turning it over to Lucia and the team from ONC to just walk us through the roadmap. There is...go ahead and go to the next slide, we'll just go ahead and tee it up, which just is sort of a bit of a framing. There are some general questions that have been asked of the entire roadmap for all particular pieces of it and then identification of two particular sections, sections G and H, involving consistent representation of permissions to collect and share identifiable health information as well as consistent representation of authorization to actually access that information. And we may take those up in a slightly different order, but we will definitely hit on both topics. So I think I'm turning this over, Lucia, to you.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Thank you Deven; good afternoon everybody or good morning if anyone is still on the West Coast. The first thing I wanted to say is, we are very interested in the workgroups feedback and each of you also is an individual or works for an organization that may have its own opinions. I just want to remind you that although we are soliciting particular input from the workgroup, nothing in that process prevents you or your organization from otherwise submitting comments; this is a public comment period.

And the second thing I would say about that is, the whole of ONC is sort of anxiously waiting to see what people have to say about the ideas we've committed in this very long and detailed document. So please do take the opportunity to get your comments in. For those of you not keeping track, the comment period closes at 5 o'clock Eastern on April 3.

So, next slide, please. So what I wanted to spend a little bit of time today talking about was some of the framing that we've done here in the Chief Privacy Officer's office to help us structure the sort of 17-20 pages that were our, literally our portion of the roadmap. And again, for all the other portions of the roadmap, please read them, please comment on them if you would like. We really focused ours on how do we ensure appropriately secure information, appropriately private information and appropriate interoperability.

And so I want to sort of start with some of the slides that I did, I reviewed for the assembled thousands, literally, at the annual meeting. And the other thing I'd say is, for those of you who are committee participants, I do not mind being interrupted, but if you want to wait until I get to the end, there are only about 6 or 7 slides here that I'm going to go over, that would be great.

So, we've used the term of interoperability as the ability of a system to exchange information with and use information from other systems without special effort on the part of the customer. And in that definition, that's a framing definition for the whole of the roadmap and that's what we want to achieve when we talk about interoperable data. And you all know that we articulated a vision last summer for interoperability over 10 years.

As we dug into how do we ensure that we are on the road to attain that vision. A significant symptom of the current situation that we observed, those of us here at OCPO as well as lots and lots of feedback from the field is that in the space of privacy in particular, there is not only a significant amount of confusion, but there's also significant variation and in fact, in the rules across the states and even within jurisdictions across the policies of particular organizations. Next slide, please.

So what that leaves us with is kind of a patchwork where senders and receivers are not 100% confident of what each other have to do. The patchwork yields different expectations or different understandings about the caliber of the data that might be received through exchange. It yields a lot of concern about liability because of that confusion. And it makes it extremely hard to take advantage of the power of modern machine learning because the rules can be so complicated that we are not quite sure what to ask the machines to adjudicate. So this is our little illustration of that; it's very clever and cute, but it's kind of memorable as well.

Here are some observations, in detail, about that that you'll see called out in the roadmap. One thing we figured out is that while the rules themselves may vary in their very detailed content, there's actually quite a lot of philosophical alignment across the states and nationally about what the rules are trying to accomplish. For example, there are lots and lots of variations of rules about whether and to what extent special rules should apply to mental health information and there may be differences of opinion about what the information is, but all of those rules philosophically are trying to do the same thing, which is protect some of our most vulnerable populations from adverse consequences and discrimination. That's one example; I could give you many and if you ask me later, you'll hear about them and they're laid out in the roadmap in detail.

Another area where there's a lot of diversity is in the sort of philosophy that arose after HITECH or in the wake of HITECH as we were trying to implement it which is, to what extent should individuals be given a choice about whether their data is available for exchange or not; even ordinary medical data that's not subject to special rules because of its clinical content. So you guys will all remember that opt in/opt out conversation; in the roadmap we were trying to move beyond that to talk about choice.

And one thing I will say about this is, people have asked us, since we published the roadmap, do we mean that everyone should be offered a choice or do we mean that there should be standards when choices are offered. And it's really the latter; we don't have an opinion, the law tells us whether choices should be offered or not. But if choices are offered, then we've got to figure out a way to bring standards to that so that foremost, the people making the choices understand what those choices mean and secondarily, the physicians and providers who are trying to take advantage of interoperable information understand what those choices mean.

And we have that diversity within our state privacy laws and moving further down the system, we have that diversity, in the absence of statutory enactments, we also have it in the case of organizational policies and procedures. We detailed this in, I don't know, it's a page or two, just a bibliography documenting this problem. For those of you guys who have been working with ONC since the HCPCS days, you'll be rolling your eyes going, oh my God, HCPCS, I forgot about HCPCS; but this is a well-documented problem. What our goal is is to not re-document it, but to build on the documentation that we have and start trying to come up as a collection of dedicated people, how do we solve for it. Next slide, please.

So this slide just represents the findings of a report that we hope to publish on our website soon and we asked MITRE to do some research regarding whether there were, in fact, technical barriers to electronic consent management. You'll remember that this workgroup has spent a lot of time on consent and there's a point I'm going to...before my time here, but I'm going to say in early 2014 where you kind of referred the problem to the Standards Committee in hopes that there could be an analysis of, were there technical solutions that have been overlooked to help solve this consent landscape problem.

The upshot of that analysis, which you guys will hear about more later, when we get this document published, is that we have the computing power to do this, but people don't know what to program those computers to do because the rules environment is so complicated. And this is just a little infographic kind of outline with the different layers of complexity to this problem. So I'll go from the bottom to the top.

The bottom, green, we have patients under HIPAA rules who have particular consent rights as to say, psychiatric notes or they might have...their physician's office may have paper in place. The orange one, moving one up, is that consent when it's documented is it being documented on paper, which then has to be rekeyed or re-transcribed to somehow connect in a system to data. Or is it, in fact, being captured electronically or some kind of in between method like an e-signature on a PDF. We have how the systems themselves adjudicate consent, what they look for. We have the architecture of the health information organizations and health information exchanges; are they matrix? Are they hub and spokes, etcetera? We have all the different consent models; is it opt in? Is it opt out? Is it opt in with restrictions? Opt out with restrictions? Is it about the physician? Is it about the location? Is it about the date range? I've seen all of those.

And then on top of all that, we have the actual laws and regulations that apply. So we have laws and regulations on sensitive information, which of course derive from open, democratic debates that happen in state legislatures. Yes, those debates may have happened many years ago, even decades ago, but they still happened in public as a matter of everyone weighing in. And we also have the similar situation but for sort of this new advent of electronic exchange or not electronic exchange. So really complicated environment. Next slide, please.

What can we do about this complicated environment? So this slide is kind of my summary slide on where we're trying to go with this. I've coined the phrase "computable privacy;" people might or might not like that, but will start again at the bottom and work our way to the top. We know from this committee...this workgroup's work in 2010 as the Tiger Team and even before that HIPAA lays a foundational...a foundation, which is kind of the minimum and it has in it the concept of permitted uses and disclosures.

And those permitted uses and disclosures were intended to, and in fact for many years operated kind of as background rules allowing payers and providers to move information that they needed to about their common people back and forth in ways that they needed to, whether it was for prior authorization or care management or retrospective review or fraud or HEDIS or referrals to specialists. I'm sure I've forgotten things that are important, but you guys get the idea. And I like to call those background rules because at the end of the day, they're rules that operated...they told all the actors in the system what to do, even if there was no consent directive on file for the patient and the consent directive, to the extent it was given, operated to override those background rules.

So the analogy I like to give is sort of like trust in estates or wills, right? If I die tomorrow and did not have a will, then there are some background rules that would kick in that would adjudicate my property, whether I did anything or not. And the will is the way I write down what I want to have happen instead of those background rules. And that's really...a really good way to think about HIPAA is as background rules.

In the environment of these background rules and permitted uses, we have, in fact, had a manifestation of choice to exchange or not. So, it's happened; it's here. And what I think we need to do to get to interoperability is bring some standards to that activity. People capture it in different ways, we worked really hard to try and find a technical standard that we could put in the Standards Advisory relative to basic choice, couldn't find one; lots out there, none seems to be dominant. So that's definitely a task is to try and bring some standards to the situation where individuals are going to be offered the choice of having their data exchanged or not.

And then the third layer of the cake, and again, you have to build a cake from the bottom up, you can't start with the top; is this granular choice. So in my world, lawyer style, I look to the rules first because they're already definitive statements to the extent they're clear, of public policy arrived at from open debate across an entire jurisdiction. But there are other levels of granular choice as well, and you'll see that discussed in detail in the roadmap.

The other thing to remember about the three slices is they kind of correlate really nicely with our 3-year, 6-year and 10-year plans. So first three years we really want to focus on permitted use is the fact that under HIPAA a lot of information could be moved right now, today, using the background rules for improving the treatment and health of individuals.

The second tranche, that year 4-7, 4, 5...yes, year 4, 5 and 6, how do we get to standards relative to the choice to exchange or not, that basic choice. Year 7-10, can we harmonize the wide variety of rules we have about granular choice so we can harness the power of computers to help capture pers...adjudicate and persist choices people make as to those legally sanctioned clinical conditions. I think that's my last slide; there may be one more.

Yeah, so this is kind of a narrative version of the cake slide, but I like to use the cake slide because that's going to stick in everybody's head and they're going to remember, oh yeah, that three-colored cake and then they're going to wonder why it wasn't chocolate. Because chocolate would be all brown.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

That was my thought Lucia, but...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I know. So obviously near term policy goals, we want to remind people that HIPAA permits exchange for treatment, payment and healthcare operations under their permitted uses/background rules. We want to get to the place where for basic choice, if it's offered, it's offered in ways that are technically standard so that we can explain to people what that means; the individuals who are making those choices and to physicians who...where those choices are going to impact the data they receive or disclose. And then third, obviously in the last...the long game here, harmonize the categories of legislatively defined special conditions, figure out a way to get that philosophical alignment to also be well aligned at an implementation level, so that we can capture people's consents using all the powers of computers that we have today and those that are yet to come.

Next slide. So let me pause there and see if the workgroup has questions about that general concept and then we'll talk about authorization.

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

David.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Hi, David.

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

Hi, Lucia. Thanks for the reminder and reintroduction of these complicated ideas; you did that nicely and that was refresh...good to refresh my memory. I have lots and lots of thoughts that I'll probably defer until we get deeper in, but, one notion is to...or one thing that strikes me is that the distinction between the bottom layer of the cake and the top layer of the cake actually probably, to me anyway, implies that there's more like a 7-layer cake than a 3-layer cake, meaning...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Maybe...you mean like it's a torte? Let's have really good cake here.

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

Yeah, exactly. Something with many different delicious layers, but each one of which gets progressively harder to do and benefits a progressively smaller percentage of the population; in other words, a smaller percentage who would be willing and ready to take advantage of the more fine-grained control. So, I think in the long run the practical challenge, once you get past permitted uses, sort of easy win, which won't be easy, but at least it'll be fairly uncontroversial, is to figure out of the subtleties between basic and fully granular, where's the right line to draw that trades off the complexity of implementation and usage against the benefits from the increasingly smaller percentage of the population who is willing to take advantage of it.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I think that's exactly right, David and I would also add to that that it becomes particularly complicated when you start veering away from law to policy because policy may or may not have been subjected to the same kind of open and public debate that a law is, on the one hand. On the other hand, it might be more contemporaneous, some of the laws are old. So we have that challenge and envision even across the laws we have wide variation.

We have lots and lots of states that have specialized laws on mental health and a far fewer number of specialized laws on HIV/AIDS. So you have kind of a...your pyramid gets pretty steep as you work your way up that, stretching the metaphor to the breaking point, as you work your way up that top layer of the cake. And the last thing I'd say about it, of course, is right, ONC, what we're trying to do here is do some very public education and diagnosis. We don't have a magic wand, changing a law or changing a state's policy has to be something that's embraced by the state.

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

Yeah. No, those are all good points. The other comment I'll make, just to add complexity from a different angle, so this is now not talking about the layer cake anymore but the...what in other industries is referred to...other industries that try to protect content refer to the analog hole, which is to say that the medical...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Is that hole with an "H" or whole with a "W?"

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

"W..."

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay.

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

..."no H." It's the ability for knowledgeable a clinician or certainly a knowledgeable hacker to deduce information about the patient from the non-restricted parts of the record, simply because the pattern is so obviously describing somebody with a particular restriction. In other words, it's very difficult to selectively erase knowledge from a comprehensive medical record, even if everybody implemented the technology appropriately. And at some point you run into just the practical limits of, you can't erase that knowledge.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I couldn't agree with you more and I think that is an important thing for people to be discussing publically.

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

Yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Because at the end of the day we spend a great effort to train our clinicians to actually make very educated guesses.

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

Yeah, that's the goal...I mean a good diagnostician knows what's wrong with the patient by listening to the way they walk down the hall.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Exactly. And we have to think about...that's something that's so important we invest years and millions of dollars into making sure our physicians can do that and we have to think about that in light of the fact that we may also want to protect people from adverse...we have to recognize these laws and these policies are in place because in fact discrimination occurs, because in fact people are treated differently because of their health status and that's a very complicated balancing act.

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

Yeah, and of course it raises the question of whether the harms being done should be what the focus of the law should be on rather than the protecting the data because the data will get out.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

It's an important conversation, but it's one that ONC's capability is talking about how it impacts electronic health information, the bigger discussion. And you may...you guys may...this may be foreshadowing what comes back to you relative to big data; I don't want to go down that rabbit hole right now. But, how do we maximize the social benefit of what we can learn from the data while minimizing the harm that the way that data is used causes. That's a really important question that's not unique to this problem. Other questions or comments?

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

This is Gil Kuperman. Lucia, I'll echo David's thanks in having you lay out this domain concisely and clearly and thanks for the walk down memory lane with the HCPCS initiative.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I love that HCPCS work that was great work.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

It was, it was; no, it gave a great sense of what's really going on out there as opposed to on paper what's going on. So, that was very worthwhile. I'll bite into the cake as well, as opposed to David who wanted to start near the top with...near the icing I guess. I'll start near the bottom and, one of the questions is the distinction between what's a permitted use and what's basic choice.

And this is probably more an observation, a comment rather than a question but, HIPAA allows the use of the data for clinical purposes. But, I think the vision there was one, a communication between two parties and in an interoperable environment where theoretically, someone could see "all" the patient's data, even if it's for a clinical environment, but that just makes folks a little uncomfortable. And so here in New York State, where I am, as we were developing health information exchanges, the State Department of Health said, wait a second, even if it's for clinical purposes, we may want to have a different set of policies around that. And so, you have a situation where even though it's for clinical purposes in a certain kind of environment, that that may create the need for policies which then might create hindrances.

So, I mean, I guess one po...one thing I wonder, and this may be too big to get into now, is part of this maybe clarifying what is allowable without a person's consent; you know, to clarify that piece of the puzzle and put that in the lower layer of the cake rather than moving it up into basic choice?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I think that's exactly the idea, Gil. And to quote David from the joint FACAs whatever, a week and a half ago, we are definitely trying to figure out the best way in concert with OCR, and I think Linda's on the call today, to give the best educational materials we can that help people understand the rules as they exist right now, today with examples that are meaningful for the way medicine is delivered, healthcare is delivered today.

So what you're real...so that's sort of next paragraph, I think we cannot forget the concept of necessity. And Linda and I could tell you, and all the lawyers on the phone call tell you the difference between necessity applies to payment and healthcare operations but not to treatment, like there's a whole like...there's a whole thing about that which I think we can really build on in explaining what the permitted uses are, how the background rules actually work. And we have a great partner in OCR to help make sure that whatever we're sending out into the universe to improve people's understanding is, in fact, an actual reflection of the current guidance.

I don't know Linda if you want to add anything about that, but I think Gil's pointing to this piece we know is there, which is necessity is really...it's an important part of the Fair Information Practices and its built into the current HIPAA rules, but it does require a little bit of thoughtfulness to determine what necessity is in an applied setting.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Office for Civil Rights

No I, thank you for that. You're right, I mean, what is necessity, what isn't necessary is the conversation that needs to happen. But I do think we can do a better job explaining what is already permitted under the rules because, in fact, that standard doesn't even apply to disclosures for treatment. And I do think additional guidance will be helpful, but we're happy to talk more about what it is you think we should focus on in terms of getting out guidance.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

Thank you very much.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Any other questions or comments before I move on to authorization? All right then, so I'm going to start back up on slide 8, and I'm not going to read the slide because I think that's really boring. So I'm going to kind of talk out of my head. We actually had a pretty significant debate as we were working on the roadmap about authorization, because it's a term that has really two meanings in health IT in general. One is the meaning that Linda and myself, other legally people are familiar with which is, an authorization is something that is both a piece of paper a person might sign to authorize a disclosure, and it is the content of what that piece of paper permits.

And there's another kind of authorization which is sort of when we look at it from the systems perspective, which is, within the system, what is authorized. And that actually connects to role-based access and a few other things. And so we had this big discussion in the drafting of the roadmap about what it was we were trying to get to and we came down in this place, which is, we really wanted to talk about...we wanted authorization as a definitional point in the roadmap to refer to the activity of what is allowed to be disclosed.

Because that allowance, that permission applies really in a kind of media agnostic way; a patient who might sign a piece of paper called authorization or log on to a website to authorize something to be released, that release might occur through a secure email, it might occur through health information exchange, it might occur through a fax, it might occur through a photocopy and mailing or photocopy and hand delivery. Any one of those ways it might occur; but the content of that disclosure is what's been authorized.

So that's the first thing I wanted to say is, in the roadmap, we're really talking about authorization as the scope of what is permitted to be accessed, used and disclosed, to use the HIPAA verbs. That doesn't mean we're going to be ignoring how is authorization represented and how do computers understand whether authorization has applied or not. So that sort of gets us to the second half of this slide. At the end of the day, we have to have, what we're looking for, consistency.

We know what an authorization is under the HIPAA regulations. We think we have a good idea about what it is when state laws require writings to release special kinds of information; we just spent a lot of time talking about that and we need to ha...understand how to represent that in data so that the users of the system, wherever they are, can have confidence that they are receiving what they're authorized to receive or they're disclosing what they're authorized to disclose.

The second thing I'm going to say about that is we also have to...we talk in the roadmap about the necessity of people...that trust environment. And I know you guys have all been doing this even longer than I have, but I've been doing it for a long time; a recipient has to trust that the discloser disclosed what was authorized. And we have to build stronger standards so that second guessing doesn't cause impediments to interoperability. Next slide, please.

So before I do this next slide, I want to make sure that you guys don't have questions about the choices we made about authorization and you understand...when you go to read the roadmap and work on it in detail, you'll understand why we did what we did about authorization.

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

So Linda, it's David, one question...I'm sorry, not Linda, Lucia.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

That's okay, I know you meant me, David.

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

Yeah, I apologize, I was thinking about my question harder than I was thinking about how to say your name. Is the notion...when you say compu...can you cross-correlate when you say computable privacy with this authorization notion? What...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I can do that really easily but you'll say, oh my God, she's daydreaming. So I've had, in past life, the dubious pleasure of actually trying to take codes and classify them so that we...so that the person for whom I was doing this can actually say, this is within the scope of this rule and that's not within the scope of this rule. And for all the physicians on the phone, you'll know how complicated that process must have been, very...a lot of work by lawyers and doctors in collaboration.

And I think that what that has taught me is that it's in fact possible to identify what is information related to mental illness. If we can define mental illness, we know what it is in data, but we have to connect those two things so it is theoretically possible to have an authorization to release mental health data that then can be connected to actual clinical content in the data itself.

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

And your assumption is that at some point in this 10-year time span, and I'm not holding you to dates, but...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

You can start a betting pool, David.

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

...yeah, the spirit of the roadmap is that that question could be answered without a human having to step in and adjudicate.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I think there will have to be some human work to put the pieces in the right order, I can see mapping happen with humans. But I can see mapping, you know, mapping happens in a way that becomes...then becomes something that's sort of built into the system. I'll give you a little anecdote.

I was talking to some developers in a State and they were talking about consent and they're building a tool and it's got date ranges and physician locations and I said, yeah, but what the doctors want to know is whether they were allowed to release it by law and that's clinical categories. And they went, oh, we never thought about that. So I think there's a lot of opportunity for dialog where we can educate each other as we, thank goodness we have 10 years, as we try to figure out how to ensure that when an individual says, I don't want you to release this type of data, then we know what that data is.

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

Umm, okay. I mean, I think...yeah, that's a really hard problem.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

You know what, I almost put as my...on my signature line, what John Kennedy said when he announced the Apollo Program, we don't do this because it's easy, we do it because it's hard. This is a very hard problem, but this is a significant aspect of interoperability and if we don't try to tackle it, we may not get to where we need to go ever.

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

Yeah, although we have to test that statement against this notion of more optionality in the...in between basic choice and fine-grained control...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Um hmm.

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

...so, when we talk to clients and patients who use the CommonWell data sharing model and explain to them the sort of opt in or opt out as a whole and then present them the choice of this doctor can share versus this doctor can see; that makes a lot of people very happy.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Um hmm.

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

And that is a coarse-grained approach to granularity that seems tractable and is acceptable to a large number of patients, not certainly everyone.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Um hmm.

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

So, being able to compute it down at the level of this ICD-10 code is covered by this XML restriction, which went through a rules engine and kicked out as still valid, that's where it gets really challenging to do. And then you may discover that the office note exposes all the data anyway...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Um hmm.

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

...and you've gone to a lot of trouble and haven't really...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yup. I...absolutely and that's exactly that kind of feedback that we're looking for. You guys are the experts and/or the public to give us, which is where are we unrealistic? Where are we realistic but should be thinking about these things?

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

Yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Where can you say, go team? All of those things.

Donna R. Cryer, JD – Principal – CryerHealth, LLC

This is Donna Cryer; I wanted to pick up on that last point. I think the schema that you were describing Deven, makes a lot of sense as an interim stage between what we're discussing because as a patient, to be able to say I would like all of my mental health information to be shared or not shared or shielded from a particular provider. To be able to operationalize that, I would see as very burdensome or very difficult for a lot of physician offices to do. But to be able to have a sort of automation that all these ICD-10...and information are sort of automatically mapped and pulled out. I think it would be very helpful in terms of oper...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Operationalizing.

Donna R. Cryer, JD – Principal – CryerHealth, LLC

...operationalizing, thank you; what a patient's preference is and what a physician's workflow can handle.

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

And this is Kitt, Kitt Winter. I just wanted to make sure that I'm on the same page. Are we really looking to define a semantically interoperable authorization and consent process? And how those authorizations and consents will be transported and when to the holders of the information? Is that what we're looking to outline in this roadmap?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So, this is Lucia responding and I welcome other people's response as well; here's what I think we were thinking when we did the drafting. Again, this is a draft for comment, so you guys get to tell us if we're right or wrong. So first of all, you've got to have...the fundamental step here is, a person has to authorize; either the law authorizes a background rule, let's put that aside, we're talking really about the situation where a person gets to document...make a choice about their data and that choice results in authority to release or not release.

And so that's number one is, we've got to have a way for people to document their choices; that might be standards relative to that documentation in the basic choice layer of the cake, and we could build on that for other choices as well, right? With standards...process where you start with something and kind of build out and apply to new context; but that's the first step.

The second step is, the holder of the data has to understand what's been authorized; so that's about representing it in the data. And then the person who's seeking that data or to whom that data's being disclosed, it can go either way, have to understand what they're auth...what can be released to them. So it's kind of all of the above, Kitt.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Except not...so this is Deven; not at the level of deciding the standards, right?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Correct.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

So, our job is to provide comments on this roadmap in terms of the policy directions that it's taking, not the technical piece of it.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

That's right. And that's why there are 10 years here as well, Deven, because we're going to have to work a fair amount on the policies...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

...before we can actually enact standards.

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

Yeah and...this is David speaking...

Linda Kloss, RHIA, CAE, FAHIMA – President – Kloss Strategic Advisors, Ltd.

So, this is....

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

Go ahead, I've spoken enough.

Linda Kloss, RHIA, CAE, FAHIMA – President – Kloss Strategic Advisors, Ltd.

Thanks, this is Linda Kloss and it strikes me that one of the challenges will be to make sure that the rules, what we call the background rules, are in fact more complete, that based on this discussion it's not just identifying how better to train on them, but there are some foundational things that are missing; the accounting for disclosure guidance, access logs, minimum necessary definitions and things that, in fact, this workgroup has been working on. So I sense that there may be some triangulation with interoperability triggering at least some return to foundational concepts of where we need to round out the background rules based on current law. Is that on target?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So this is Lucia and I'm going to delegate to Linda in just a second and just remind...so, ONC, how the actual rule...the background rules get fleshed out and elucidated is squarely in OCRs ballpark and much of their annual work plan derives from competing priorities, funding, a whole bunch of things. I don't know Linda if you want to address that, I know that you guys have had some challenges in getting some of these off the ground and I don't think it's your...it's challenges probably from external factors.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Office for Civil Rights
Right.

Linda Kloss, RHIA, CAE, FAHIMA – President – Kloss Strategic Advisors, Ltd.

But I...this is Linda Kloss again and I wasn't suggesting...I was just suggesting that one of the year 1-3 challenges or one of the issues that this workgroup needs to take up is what might need to be better elucidated as background rules.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yes Linda Kloss and I think if you looked in the roadmap, which we haven't given slides on it, but you'll see there's sort of several commitments and one of those commitments is OCR to engage...I'm going to truncate what's in there Linda Sanches, but OCR to sort of engage in a conversation about whether additional guidance is needed and of what kind? So, if there were thoughts about that, I'm sure people would be delighted to hear what you had to say.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Office for Civil Rights
And that is true.

Deven McGraw, JD, MPH, LL.M. – Partner – Manatt, Phelps & Phillips, LLP
Excellent.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I'm channeling my inner Linda Sanches. So Linda Kloss, does that make sense?

Linda Kloss, RHIA, CAE, FAHIMA – President – Kloss Strategic Advisors, Ltd.
It does.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

We recognize that there might be opportunities for additional guidance. We, each of us personally has ideas in our own minds about what those areas are, what their priority levels are and that will have to get sorted out, of course.

Linda Sanches, MPH – Senior Advisor for Health Information Privacy – Office for Civil Rights

And I think they've all been worked on to some extent or another, but the point is that the fabric of the background rules isn't yet complete and that makes it more difficult to move on to basic choice.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I think that's right but I want to also say a word of caution. One of the best things about the background rules right now is that they're media agnostic and people forget that and that's why I gave the example of a disclosure by secure email or exchange compared to photo copying and messenger pick-up; that's sort of like the complete spectrum. And we really should embrace that because that means that...because they're not media specific and they're not checklist oriented, they actually have some flexibility we can take advantage of as we do this next stage of work.

All right...go ahead.

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

Is there time for another question?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yeah.

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

This is David Kotz, sorry I joined the call late. And I was looking at the last bullet on the current slide and wondering if this helps individuals know where they have data and what authorization they may have given in terms of who can access that data or how it can be shared? I know personally I would find it difficult just to track down all the authorizations I've given in the past and if I wanted to change them, how to do so?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I think that that's an important thing, David. I don't think the roadmap gives that level of detail about how that might happen and I'm not sure that...

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

Right, I guess I'm wondering...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

...this is a philosophical concept, this last bullet on 9 and I haven't actually gone through 9 yet; so, I think you're right and it's a great segue and I'd like to go through the rest of 9.

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

Oh, sorry.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

But, no, that's okay. It's an interesting thing if you think back to PCAST, they sort of had this idea of some national consent registry...

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

Um hmm.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

...and that might be that that you're talking of, but we have so much to do before we could even consider doing that, that's kind of one of the...it's hard to do a registry when the rules vary so much, because then how do you know what you're capturing when everything is so widely varying and a person who moves from Ohio to Kentucky might have a change of rules environment.

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

Right. I guess...I certainly wouldn't want to specify how, but I guess I was thinking as a policy matter is that one of our goals, eventually, to make that possible?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I would be interested in your thoughts on that.

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

Well I would...that would be my vote.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

All right. So let me talk a little bit about 9. So one of the things as we are having this very detailed internal discussion about what was authorization, we really tried to distinguish authorization and role-based access. So role-based access is an element of the Security Rule and it basically says that the access a person has to data should be driven by the PHI needs of their role, and not everyone has a need to see PHI.

I'll give myself as an example, healthcare attorney for a gazillion years, I never want to see the stuff except my own; like I don't want it on my computer, I have a role that doesn't require me to actually know the content of an individual's record, I just have to know about how those records work legally. So that's an example of role-based access; I don't want any. Hopefully you guys are all thinking about this yourselves as well. So we do need to ensure that standards we articulate account for role-based access.

And that role-based access becomes the...as it already is in regulation, it becomes in practice the norm. And I think that gets to was it you Gil who was talking about necessity? When we have role-based access we start to create technical boundaries to capture the idea of necessity.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

Okay.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Does that make sense?

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

Uh, yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I mean, does it make sense, not do you agree, but does what I'm saying make sense? Do you understand what I'm saying? And then, of course, different roles are going to have different accesses so the role that a primary care physician might have or the people taking care of a patient who is quite ill and has been in the hospital for a while is going to be pretty different than the role that a researcher has or the role that an accountant helping a physician do their annual paperwork, financial paperwork has. Each one of those things is going to have its own level...appropriate level of access and role. That's why I used myself as an example; I might, at some point in my career be advising physicians, but that doesn't mean I need to see their PHI.

So, we have to think about that as well, that whatever we...however we're building standards for role-based access, we account for all the roles that will be needed between year 1 and year 10 as we grow this learning health system.

And then that leads me to the last bullet which the other David was just commenting on, and of course, we do have under the rules already, the HIPAA rules already, individuals have a right to know who has accessed their record. And we have to figure out how to make that real information, whether it's enabling individuals to keep better track of authorizations they've given or who's taken advantage of an authorization that's in place. All that is...we have that all in theory, but we haven't figured out how to operationalize it and implement it nationwide yet. Next slide, please.

How am I doing for time, Michelle?

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

You're okay, you have until 3:30.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Okay. All right...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

But we...the call is until 3:30...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yup, I think I'm done and I get to flip it back to you now, Deven.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

I was going to give you a break Lucia, but that...it was terrific to have all that background and people may, at this phase, I wanted to start to sort of move us into at least a high level overview of what the specific questions that are relevant to these particular sections of the roadmap, beginning with some sort of initial impressions that your Chair and your Co-Chair had when we first read through the roadmap. But those are just to kick off the discussion not at all to end it. So, before I move to that, though, I want to see if other people have any particular questions for Lucia. I mean, you're going to remain on the line, right Lucia, so if they come up...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Oh yeah, I'm here until the bitter end.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay. Excellent.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

We're back on the chocolate theme.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Back on the chocolate them, exactly. Okay, well one of the reasons why I thought it was so incredibly helpful to have you provide a description of what's in the roadmap was because I think when you actually read the text of the roadmap, despite what I'm sure were yeoman's efforts to try to be as clear as you possibly could have, I don't think that your...for example, your distinction between what is authorization of a record and how there's that baseline layer of the cake that involves HIPAA and the permissive ways that you can access and share data, whether you have sought the patient's consent or not, that that's really the baseline that we're operating under.

Because I think a lot of folks may have initially read the roadmap and thought that the direction you were heading in was to sort of endorse more of a basic choice framework where the rules provide really the operating...the existing law provides the operating rules for how we share data, absent a law, for example, that requires choice or a policy that requires choice where choice has been articulated. And then basic choice is the level at which that choice gets articulated. I think there were a couple of places in the roadmap where it seemed like the choice was the default and the rules would just kick in if you didn't have a choice.

And I thought your explanation was...on this call today, was incredibly helpful at sort of being clear that we have a whole environment, from a regulatory standpoint, that does lay out the circumstances under which data can be shared and that we have some work to do to make sure that people understand it. And potentially also some work to do so that that sort of baseline level of ability to access data can be communicated in circumstances where one needs to do that in order to assure interoperable exchange.

And so I just thought the explanation that you provided was so clear, but questions about this issue did come up in the Health IT Policy Committee and Standards Committee when you first unveiled it and I'm just really glad that the workgroup members and members of the public who were on the phone have had the benefit of this sort of deeper dive that our workgroup call allows into those particular sections. Because that was one of the things that we observed.

The second thing I want to say is that we deliberately moved subsection H, which is the section on authorization to access health information ahead of the section of the roadmap G, which is about individual permissions, the choice issue because in our opinion, the permission of an individual when that permission is sought and when it is articulated, is just one aspect of the authorization question. Are you authorized to get this data? And you may be authorized by law, you may be authorized by individual permission, you may be authorized by a combination of law and individual permission; but, the choice is one component of a bigger debate about...a bigger set of questions around authorization. And so I actually thought it would be helpful for us as a working group to take on this issue of how do you communicate to share data and to what extent do we need to do that in order to facilitate an interoperability environment.

On the specific roadmap findings and recommendations and conclusions around audit logs and audit trails, as Linda Kloss alluded to earlier, we do have some previous recommendations on the accounting of disclosure issue and some recommendations on some of these other issues too that we certainly can go back and look to and see if they're helpful in addressing some of these roadmap questions. For any of you who have read the roadmap, it's particularly encouraging to see how often our recommendations that we've issued in the past are directly cited in the roadmap. And that's...not only is that incredibly validating, but it's incredibly helpful. But we may be able to rely on those recommendations in a greater level of detail as we go down the road to answering some of the more detailed questions here.

Similarly, there have been a lot of recommendations from the National Center for Vital and Health Statistics on issues related to the more granular choice questions and the laws that exist both at the federal and state level that require patient consent or authorization for the sharing of certain types of data.

And then the last question here, and one that has been particularly perplexing me, but I would be really interested to know if other members of the workgroup are similarly in this...of this mindset which is, I have to admit I don't get what is the reason why we would have to persist authorization down a food chain of sharing of data when number 1, the purpose for which the data is being authorized is likely to change with potentially each and every transaction and whether or not a particular entity has to honor that initial authorization, with respect to subsequent access or disclosure may be dependent on a combination of law and policy.

So if for example I as Deven McGraw, physician, I have legal authority either through the patient's consent or through law, to share my patient's record for treatment purposes and I send it to the physician to whom I'm referring my patient. The fact that I communicate that I had authorization to send that, I don't get how that's at all binding or at all relevant on the recipient provider. And I'm just scratching my head with this and I know when I've raised this with Lucia and others at ONC, they have let me know that they a lot of times get comments from providers and others that this sort of persistence of authorization is something that's really needed.

And I just have to admit that I'm...absent an environment where legally the disclosure attaches to the data like it does in the case of substance abuse treatment data where you have to honor the consent or go back and seek it again; I just don't get what the issue is and that's...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So Deven, let me...this is Lucia, let me...now you guys get to see how the sausage is really made.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So let me just give you a little bit of a counterpoint and then I'll let your...the workgroup members chime in. So imagine that we actually have some standards relative to if basic choice is offered, what might that look like? And if an individual says, I want my data to be...my not specially protected, ordinary medical data to be available for exchange always, that I can see that every person who might touch that data would need to know that that was, in fact, the case so that they don't have to go and get a reauthorization. So that's an example of persistence.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Well, and I get that, but that presumes a legal regime or a set of consistently applied policies across multiple settings where such consent is needed. Because how would I otherwise know to even look for it? If I'm in a HIPAA environment and I'm allowed to share data for treatment purposes and it comes in my door and, okay, so I either presume or I see in the data through some sort of computable standard that you have had...you, the disclosure, have had authorization to send it to me. But how is that relevant to me, if I'm not in a legal or policy regime that requires me to get choice as well?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I'm not sure it is, but I don't think that...I think there are going to be environments where it is relevant.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right, I mean we know it is in Part 2, but I'm sort of hard pressed to define where else that's the case.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So yeah, so I'm going to back off because I...this is something we hear from clinicians and...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Ah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

...we've got a lot of them on the phone.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yup, no, I hear you. I mean I'm just...I'm really struggling with this one, so...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

And maybe it has to do with the clinicians being confident that they can use it and, in your example, specialist "A" now needs to refer to specialist "B," how does that work? I'm not a clinician and so I'm not an expert on that.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay.

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

Doesn't that just fall under the HIPAA direct treatment exemption?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I would hope so, but I'm telling you, we hear this all the time that the physician wants to be able to know that the...what rule...the rule that allows them to access user disclosed or re-disclose, they want to know that that's connected to the data in a persistent way. If that's wrong, if we've got this wrong, that is exactly why this is a draft roadmap.

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

But the notion of the background rules say that it doesn't have to be attached to the data because you have...the clinician has the right guaranteed under HIPAA to do so, to exchange it.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I'm with ya. I totally understand where you're going and again, you guys are going to be commenting on and so are some of the other workgroups so we'll have to see how it all shakes out at the end of the day.

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

So let me...this is David McCallie again, just to segue on that one. On the basic choice notion that you said in the roadmap it says that some institutions may go beyond HIPAA and offer the patient consent. And what I...my question, let me just read the sentence exactly the way it was written, covered entities may, and often do, voluntarily choose to obtain an individual's consent, "basic choice" to use and disclose information about them for T, P and O. So my question is, what if the patient says no? Does that override TPO exemptions?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

To be honest with you David, I don't know because I have not been in personal position of giving that advice and we don't know whether...we know this happens factually, but the environments in which it happens vary widely from state to state as well. So...

Donna R. Cryer, JD – Principal – CryerHealth, LLC

This is...

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

But presumably if the patient says no, then that would need to attach to the data, but it's not clear to me that the next institution involved in direct treatment would be obligated if they don't have that same policy.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

You mean for information they collect independently from that patient?

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

Well or that was sent to them as part of a referral and they need to invoke another person in the institution to interpret an image or something like that. In other words, the voluntary imposition of standards above HIPAA that are enacted by one institution, does that imply that other institutions who have a right to use that data under T, P and O are so bound by the first institution's higher standards? I don't...I think that would be a hard case to make, but it's what confuses me about this notion of basic choice.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Um hmm. I hear what you're saying and I think that it's symptomatic of some of the challenges we have because we have such wide variation of how people have responded to the advent of the potential for exchange that we actually end up in exactly the situation where party A does one thing and party B may want to choose a different path and now we have unpredictability.

Donna R. Cryer, JD – Principal – CryerHealth, LLC

I think it's very important for us to keep in mind the...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Is that Donna?

Donna R. Cryer, JD – Principal – CryerHealth, LLC

This is Donna, I'm sorry. This is Donna Cryer speaking. So I think if the scenario that was painted before grounding us in the realities of this transition, healthcare system where we are, that things may be sent by FAX or courier or fully implemented electronic interchange is really, really helpful because I think this question could be answered one way if we did have that fully implemented electronic interchange. Because it's much like a...sort of a virus and a receptor so there are properties that are related to the data itself and the permission it has been given by law or the patient in terms of how it's used; and then the receptor is the role-based receiver and potential user of that information and they both have to match.

So the data has to be under a permission scheme that allows the type of use that that user is authorized by their role or otherwise to be able to receive and use that information and both sort of the lock and key or the cell and the receptor have to match. And that can be done under sort of our fully realized technology today, but it's not possible to do in a fact-based space or the realities of much of our healthcare system today. So that sort of confounds our challenge here.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Undoubtedly Donna, but I think the...I mean part of, I think, what...and this is Deven; I think part of what we're sort of wrestling with is if you have a set of baseline rules that...like HIPAA, that when they apply, allow for the exchange of data for treatment, payment and operations, the TPO purposes that David was referring to earlier, that don't require consent, are we suggesting that we move to some sort of persistent way of articulating a permission that might apply in some context all the way downstream to circumstances where it's not legally required but because we can, assuming a technological capability to get there.

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

Ooph. This is David Kotz; I think this is really interesting and my concern is that if we assume that the permissions don't travel with the data, then a recipient who believes that they received the data correctly and have the rights to use it would then apply, with no other permission indicated on the data, that they have...they can follow the baseline standards for re-sharing that data...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right.

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

...and that's fine, maybe, if that's what...if we don't want to allow anyone to impose us a narrower set of policies on their own data. So basic choice then would mean, you can have a choice, but you can't make it any more restrictive than the baseline and the T, P and O would be allowed whether you like it or not. So if we ever want to allow people to have a choice to remove some of that or to narrow the sharing, right? Then we have to have the personal references follow the data so people know what to do with it.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So Deven, this is Lucia; I want to kind of jump back in. So you guys have to remember when I was discussing basic choice, we're not saying it should or shouldn't happen; we're saying it's manifest, it's here, states have enacted basic laws that in fact, to Donna's point, say that yes, we're going to treat eData differently than we treat faxed data or mailed data.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Those state laws do that right now.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

So, but governing their own states...

W

(Indiscernible)

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Right, well just hang on a second; and sometimes it's policies that have been enacted by HISPs or designated entities or organizations within states and of course there's variation across state lines or loosely described jurisdictional boundaries, whether that's a state or some kind of corporate form TBD. Right, so it's manifest right now. It's manifest right now that people, in fact, I think this was David McCallie's point, actually have a right to say no, I don't want the basic...I don't want TPO permitted uses to apply in an electronic setting; that's manifest.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Not everywhere.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Not everywhere, but it is manifest in a countable number of...it's not rare either; it's neither everywhere nor rare.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right, but it's also not, except in maybe a more rare set of circumstances, I would argue, doesn't persist beyond the boundaries of the governed entity; so whether it's an HIE or its state...a matter of state law, it doesn't sort of attach to that data and float across state lines.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I don't know whether that's true. I know that a decision one organization makes doesn't bind a decision another organization makes about its own conduct, absent there being a law or regulation; those are just organizational decisions. But what I don't know, because I'm ignorant, is the expectation that's been set in the data isn't it...isn't, for example, in New York State, isn't it true that as that data might travel from a provider setting to a payer setting, in fact the rules do change even within one state's jurisdiction.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah, I don't know off the top of my head.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So, I don't...I think that there's...my suspicion is that there are, in fact, organizations that think they are persisting these choices in the data outside of their boundaries and/or across jurisdictions. And I go back to the FIPS and I think, how do you explain all this to a person so that they actually understand the collection, use and transaction of data about them.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Right. Whew.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Boy, this is a robust conversation.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

You guys are all so much fun to work with, so smart.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

This is Gil Kuperman; just a couple of thoughts. I mean, in terms of the question about New York that was posed, I don't know the answer to that particular question, but we do have multiple HIEs here in the state and there are some, just like everywhere, there are some kind of policies. But then the individual HIEs then kind of can layer their own policies on top of what the state policies are and as you know, as we're trying to go across HIEs doing data sharing, we're having to sweat the details of, well, do the individual HIE policies, are the congruent. And it's hard enough doing that in New York State, if we think we're going to do that kind of nationally, absent some kind of law, it just seems it's going to be tough.

I mean, the question that I had about, do the policies kind of follow the data? Do the authorizations follow the data? What about the instance of specially protected, it's like the SAMSHA data; is that an instance where you would want to have the authorizations follow, so that if I get that from an HIE and there's SAMSHA data in there, even if I got it for TPO, if there's SAMSHA data in there, then I have to kind of know that before I re-disclose, right?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Yeah, no, that is true Gil and that's the reference that we made earlier to the Part 2 substance abuse treatment data and that we've grappled with on this workgroup before.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

Yeah, so there I could see it; I'm a little...I'm not sure I kind of see the need, absent those kinds of special circumstances. So, I'll stop there.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

So I'm just going to take a moment to ask Michelle to put up the public comment slide because we now are asked to do that so people can queue up in sufficient time, rather than waiting just to queue people at the end of the call. So what we'll do is, I'll pause for a moment, let Michelle have Altarum put the relevant information up and we'll keep going as we give people time to get in the queue if they want to make public comment at the end.

Public Comment

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

Thanks, Deven. Caitlin, can you just open it up for public comment?

Caitlin Collins – Junior Project Manager – Altarum Institute

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

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay, great; we'll leave that slide up and allow people to go ahead and start queuing up. But in the meantime, what we've been asked to do on the workgroup, in addition to this very robust discussion that we've been having on issues of authorization and representation of authorization across settings, as well as permissions for data; I will say that we have a set of questions that we've been specifically tasked to focus on. It doesn't mean we need to confine our comments to ONC just to these questions, but we should provide feedback on these questions in addition to what other feedback we have time to provide. And so I'm wondering if we've had this public comment slide up long enough that we can go to slide 11, even while things are queuing up. Okay, that's great.

So this is, again, relevant to the section of the roadmap that deals with consistent representation of authorization to access information; you'll see we have about six questions to try to deal with and the requirement that's in the draft roadmap is related to this consistent representation of authorization to access health information; the sort of bottom layer of the cake, at least for starters. That when coupled with verification of identity of the person accessing the data, allows for some consistent decisions to be made by systems about access to information.

So some of the questions include: who should ONC convene to develop policy recommendations and a framework to enable consistent decisions about authorized access? How should role categorization proceed across the healthcare system? Are there a basic set of defined rules that can be...roles, sorry, roles that can be agreed upon and built on? What additional legal clarification is needed? Next slide.

Are existing standards to support authorization in healthcare sufficient to meet the needs of an evolving nationwide learning health systems? And what are the reasons for relatively low uptake of existing standards that are out there relevant to authorization and consistent representation of authorization to access health information?

And in the next slide, just to give you an overview of everything we've been tasked with; roadmap section G, which is about one aspect of authorization, which is permissions to collect and share data and then there's a series of questions here related to the topic that Lucia raised earlier about confusion, about laws that provide choice, whether it's basic or more likely at the granular level. Many of them are state law issues, are states ready to collaborate to try to create some more consistency with respect to these policies? What other methodologies could address this concern? How would we measure success at addressing complexity? What kind of timeframes are we talking about here? Next slide.

So we have some agreement with respect to approaching consent through even basic choice, even as it relates to TPO followed by granular choice? What sorts of alternatives should we be considering? And what areas of health information should be addressed first for granular choice? So a lot of questions and unfortunately, very little time to address them, but we'll certainly try to take on as many of these as we can. Let's go back to slide 11, we have about...we have a couple more minutes, I think, to begin to try to chew on this beyond the ways we've already been doing so, before we need to open it up for public comment.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

Gil Kuperman here; so, just one comment, there was one question, what's the reason for the relatively low uptake of existing standards? Just...I think one observation that I might have is that although a robust framework can be imagined that some of the other constraints of interoperability in health information exchange mean that at the early stages, folks are just trying to do the basics. You can imagine 75 different kinds of roles, but basically you're trying to get the information to the doctor. And so a lot of organizations that are doing HIE, they may envision role-based access but in fact, that's not a nut that they need to crack early.

And so maybe one principle is that we...this gets staged in a way that there can be some basic pieces put into place that enable the early stages of interoperability and then some of the more complex aspects of the framework get deferred until there's real experience with this stuff. Because you don't want to build something that's so elaborate that it's just kind of not really what's needed at a particular point in time. So, I think realizing that this access and authorization framework is going to be part of a broader landscape and doing as much as is needed, but maybe avoiding doing more than is needed early; just a comment.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So Gil, this is Lucia; that's exactly the kind of feedback we're looking for and that's why this roadmap has 10 years. There are certain things that we have to be prepared to do immediately and you're right that for the average small provider's office, I mean role-based access is not necessarily for the physician themselves, it may be relevant to his or her staff members, depending on what their roles are; but for the physician themselves, they're providing treatment, it may not be a key thing. However, moving down the road, if we want to really harness the power of machine learning, we will have to figure out a way to not only have standards brought to the roles themselves, so that they correlate to the rules to the point that was made earlier; but also to have people understand what role-based...why role-based access is important.

Gilad Kuperman, MD, PhD, FACMI – Director of Interoperability Informatics – New York Presbyterian Hospital

I'd agree.

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

This is David. It seems pretty clear you're talking about role-based access within the bounds of an institution, not just limited to the interoperability crossing bounds use case, is that right?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Well role-based access is a standard right now, David.

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

Right, right, but we don't normally think of it as an interoperability question. In other words, when we talked about opt in and opt out in data sharing, we're talking about data crossing outside the boundaries of an institution inside of which you have role-based access. But, across which we don't, because institutions don't recognize the roles of people at other institutions and they don't know who's going to get the data when it gets to the other institution.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Um hmm.

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

In other words, you really ne...I mean, I totally understand what role-based access is and computable privacy has something to do with it, but it's an even more complex question if we're talking about I think at a typical large-scale institution, we have over 300 roles in our software, each one of which has different workflow and different access patterns. Are we talking about wanting to go in and regulate that with computable consent?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I don't think...I don't think so, but...

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

Okay.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

...you guys have to tell us what's realistic and necessary, right? Because it still has to be relevant to build trust across the institutional lines, that's what interoperability is, right, with that extra effort on the part of the user.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Thank you, Lucia and all good comments to start off this conversation. I'm mindful of the clock and that we may have some people queued up for public comment, so I'm going to pause now to see if that's the case.

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

We do have a public comment...

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay, great.

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

...from John Scott.

John S. Scott, MD - Program Director, Clinical Informatics Policy, Office of the Assistant Secretary of Defense, Health Affairs - Department of Defense

Yes, thank you. I'm a DoD participant and helping to review the document is part of DoD's review that you mentioned at the beginning. I had a question about whether there's any plans at this point to include guidelines or provisions about how personal health records would be used to help facilitate exchange and I think the folks on this call can understand what the values of that would be in term of patient engagement, in terms of making it clearer that obviously there's patient consent about just what's shared. But there need to be some guidelines then about the standards and the ability to maintain data provenance so that the information that a patient would send from their PHR to a gaining facility could be trusted. So could you address that? Thank you.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Yeah, so this is Lucia Savage at ONC. So the simple answer is currently right now PHRs are outside of the scope of HIPAA regulation, which doesn't mean that won't change, it doesn't mean that that's not something people are talking about significantly, Francis Collins has talked about PHRs with regards to precision medicine. So, it's something that many, many stakeholders are aware of, but this roadmap is not attempting to make prescriptions for that activity just yet. You can see that there's a lot of specificity for the first 3 years and as we move farther down the roadmap, things become more unspecific because we can't forecast that far in advance.

John S. Scott, MD - Program Director, Clinical Informatics Policy, Office of the Assistant Secretary of Defense, Health Affairs - Department of Defense

Right, I worry that the reality is going to get ahead then of standard recommendations from ONC because the USPS has just announced the pretty large PHR project they're going to have. The VA, of course, has a PHR. The DoD enables patients to download a CCD and store it wherever, we don't actually have a DoD supported enterprise level PHR yet, but patients are going to begin expecting that they are able to share the information in their PHR with gaining healthcare systems and if we don't have some guidelines about that, I'm afraid the cats going to be out of the bag. Thank you.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

That was a great public comment from one of your federal partners, very helpful. Do we have any others? We're almost out of time.

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

Caitlin, I lost my connection so if there are others, can you announce them? I'm sorry.

Caitlin Collins – Junior Project Manager – Altarum Institute

We do not have any comment at this time.

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

Thank you.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Okay, so I just want to thank everyone for the very beginning of this conversation. Can we just quickly go to slide 16? Not 20, 16; great, thank you. This is just a reminder for folks. We have a couple of vacancies on the Privacy & Security Workgroup and so if you haven't already put in an application and you would like to become a participant, here's a link to the application page. Some of the folks that we had originally tapped to be members of the workgroup, the newly constituted one, are unable due to other time commitments to be able to participate. So, we do need to add a few members and hopefully we'll get some folks applying.

I think...and with that, we're about out of time. We did not get nearly as much time to talk about this as I had hoped we would, but we did...we were able to get, I think, a very thorough review of what's in the roadmap on the sections that are pertinent to us, which should hopefully allow us to dive into the meat of the discussion much more quickly on our next call and try to get some answers sketched out for ONC in response to their comments.

So thanks to everyone and have a good rest of your day.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Thank you, Deven.