

**HIT Policy Committee  
Privacy & Security Tiger Team  
Transcript  
September 16, 2013**

**Presentation**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

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 Tiger Team. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Deven McGraw?

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

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

David Holtzman?

**David Holtzman, JD, CIPP/G – Senior Health Information Technology & Privacy Policy Specialist – Office for Civil Rights**

I am here, but for OCR, yes.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

David McCallie?

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

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Dixie Baker? Gayle Harrell?

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

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

John Houston? Judy Faulkner? Kitt Winter? Larry Garber? Leslie Francis? Micky Tripathi? Wes Rishel?

**Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

And are there any ONC staff members on the line?

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Joy Pritts.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Joy. And I'll pass it back to you Deven.

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

Thanks very much Michelle. We have a bit of a skeleton crew on the line today. I know Micky was having some issues flying out of DC because of incidents – a shooting incident that occurred at the Navy Yard this morning, unfortunately. Also, I know Leslie Francis has an NCBA – call today. But, we'll work with who we have, thanks to everyone who was able to join us today. And thanks, as always, to members of the public who join us for our calls. What we're going to do today is to give you all a status update on the virtual hearing that we're planning on accounting of disclosures, which will take place on September 30. We're doing quite well in fleshing out the panel and getting excited about this upcoming hearing. We'll spend a little bit of time updating you on that.

And then what we're going to use the bulk of the time on our call to do today is to circle back to the conversation we had on our last call about data intermediaries, where we were exploring a number of potential ways to have our previous recommendations on intermediaries be enforced or to have entities be held accountable to them in some way. But we were not able to agree, and one of the things that we needed to do, to circle back with you on, is to just sort of frame the discussion that we had and the conclusions that we thought we came to. We have this opportunity to go over them one more time before we would present them to the Health IT Policy Committee, which, assuming that we're able to wrap up the discussion about it today, we can do, assuming there's time in schedule, at the October meeting. Paul, do you want to add anything before we move forward?

**Paul Egerman – Businessman/Software Entrepreneur**

No, I just think that's a – you gave an excellent summary and we should dive into first the issues with the virtual hearing. Because the hearing is an area where there's a lot of interest in this topic, on accounting for disclosures.

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

Yes. Thank you, thank you that almost feels like an understatement.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, a lot of controversy.

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

That there's a lot of interest. All right, so this hearing, just to remind folks, is scheduled for September 30 from 11:45 in the morning to 5 p.m. Eastern Time. It is a virtual hearing, so everyone will be online. We've done these before. We're still fleshing out the panels, but you'll see in the next couple of slides that we have a number of persons and entities who are already confirmed. We were able to finalize the list of questions, which has been sent to all of the confirmed panelists. You should have received a copy of those questions in the materials that came in your email for this particular meeting and then, of course, as we get closer to the time of the hearing, we'll have bios from each of the persons who will be giving presentations. We'll have written presentations from persons who are able to give them to us. Unlike Congress, we don't require people to present written testimony, but we offer to all of the presenters that they have the opportunity to provide it.

We also are going to be able to use our FACA blog to be able to post the list of questions and invite comments from members of the general public, who might not necessarily be giving presentations at the hearing, but who have expressed an interest in being heard on these issues. And so that is scheduled to go up on, I think September 23, so – and we probably can leave it up for some period of time after the hearing, we'll check on that. But at least for about a week before, we'll have an opportunity to collect comments from the public on the blog.

So here are a list of organizations and persons who we already have confirmed. Again, we are still fleshing out these lists with suggestions that we discussed on a previous call. We decided not to identify entities who hadn't responded to us yet and just to at least provide those who were already confirmed. But, I wanted to assure you all that we're not quite finished fleshing out these panels, in fact, they look pretty good so far. Under health plans we have Kaiser and America's Health Insurance Plans. On the vendor, business associate panel we have FairWarning, EPIC and Athena Health. In the patient advocate panel we have a representative from California State and Consumer Services Agency, as well as someone from the American Federation for the Blind, and we are still working to actually get individual patients on this panel, that's ongoing. And we have four providers confirmed, Johns Hopkins, AHIMA, Intermountain Healthcare and the Medical Group Management Association, whom we're hoping can present the perspective of some of the smaller providers.

So those are – that's the status of the Accounting of Disclosures/Transparency Hearing so far. Does anybody have any questions, concerns, thoughts they want to share before we move to the intermediary issue?

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

Hey Deven, this is John Houston, I apologize, and I got on a little bit late.

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

Okay. Hi John.

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

Hi. I noticed sort of absent from that list was anything related to HIEs, health information exchanges and I understand it's not necessarily under the accounting of disclosures regs under HIPAA, but it seems to me that there's going to be more and more focus on accounting of disclosures related to HIEs. And I'm just wondering whether there's any value in trying to get somebody from the HIE community or some type of dialogue going in the HIE community regarding this.

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

I think we do have an invite out to an HIE, we just haven't – it hasn't been confirmed yet.

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

Okay.

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

We also have a whole lot of testimony from them from the prior hearing on query, where actually a number of them spoke about the audit trails at least, and whether they make those available for patients.

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

Right. Okay.

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

Deven.

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

Yes.

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

It's David with a question. I think I missed the Tiger Team session when this accounting of disclosures was planned, but could you remind me what the trigger for this is? Who suggested that we look into this and to what end? Is it something to be presented back to the Policy Committee? Is this – I just don't – I lost track of how it got on our calendar.

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

Yes. We were asked by both the Office of the National Coordinator for Health IT, which has an obligation under the HITECH rule to promulgate standards for the HITECH accounting of disclosures provisions and we were also asked by the Office for Civil Rights to take a look at the policy aspects of this issue. They – there has been a proposed rule that was released on this, but the Office is still working on this issue and welcomes the opportunity to have additional input provided, particularly in a setting where we're able to explore both the policy issues as well as the technical capabilities in the same hearing. And so that's the genesis of it. We were also asked to invite, and we have invited, the members of the Health IT Standard's Privacy and Security Workgroup as well as the National Committee for Vital and Health Statistics Confidentiality, Privacy and Security Working Group. Their members will be sitting in on the hearing and so they'll be participating in the Q&A period, but each of our respective advisory groups will do its own deliberating on recommendations to the respective bodies to whom we customarily make recommendations.

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

Good. That jogs my memory well.

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

Okay.

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

Maybe I was at that meeting. One other question, did – I'm not an expert on the NPRM that does exist or the proposed rule, I'm not sure what state it reached on accounting for disclosures, but they made, as I recall, distinctions between access report and accounting of disclosure report. Are we focusing in on just one of those or just lumping them together and talking broadly about the notion of tracking of disclosures?

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

We are focusing – we're not narrowly focusing just on disclosures. However, we have a number of questions on the question list that try to tease out both the policy differences between tracking access and disclosure and what patient's would want and what we should be getting to them in order to improve transparency. As well as the technical aspects of whether you can make a distinction between those using software that is currently available and affordable. And so we're taking a bit of a broader lens than – on the issue than just taking the NPRM, which is still at the stage of NPRM, and assuming the particular framework that was laid out there.

But we will spend some time in the beginning of the hearing laying the groundwork for all of the participants in the public about sort of how this is – what's the history on this issue of which the key pieces of the proposed rule. As well as the key components of the HITECH statute and what's required under the HIPAA Privacy Rule, as it exists today with respect to accounting, will all be summarized so that everyone is on the same page.

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

Good. Because I get tripped up on the distinction between disclosure and access and things like that –

**Paul Egerman – Businessman/Software Entrepreneur**

Yes and –

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

– and it would be helpful if there were a glossary maybe for the participants.

**Paul Egerman – Businessman/Software Entrepreneur**

And David, this is Paul, that issue that you say trips up is actually with – by itself within the scope of the hearing, is can you make a clean distinction between a disclosure and what you were calling an access, I think OCR calls it usage in the NPRM. But ca – how hard is it even to distinguish between those two is also within the scope of the hearing. So this is – it's pretty broad and it's pretty interesting and there will be people who have some heartfelt opinions on some of these topics.

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

Yeah, probably in both directions.

**Paul Egerman – Businessman/Software Entrepreneur**

Oh, absolutely.

**Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated**

Well – this is Wes. It's been a long time since I reviewed the NPRM, too, but, as I recall, there's a requirement for enhanced accounting for disclosures for EHR systems using the HIPAA definition of EHR and that the proposed rule substituted an – a report on which people in the healthcare organization had access to patient's record, rather than a report about disclosures outside of the organization. And that's the level that has raised considerable concern, both on the privacy of the employee issue and also on the technological feasibility. Is that correct?

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

That's one – that is also a set of issues that we've included as part of our questions that we'll be diving into, yes.

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

The – I'm just scanning the questions as we speak and it's a lot of questions, a lot of detail. Are we going to limit them to 5 minutes presentation as our usual, or do they get a little bit longer, given the –

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

We're going to limit them to five minutes, but we have also built in to the hearing a lot of time for Q&A. So, to the extent that people – we're giving the presenters the – they make the judgment call about which questions that they want to focus on. We're going to continue to limit them to five minutes, but we will let them add additional information as part of the Q&A, and of course if people feel like their points have been sort of cut off prematurely, they'll have some time during Q&A to say more. Otherwise I feel like – the Q&A tends to be the place where we get the most amount of back and forth and really being able to drill down on issues with more detail. And at the end of the day, we thought giving more time for that aspect of the hearing versus extending each individual's presentation time would inevitably get us better feedback.

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

Okay, that makes sense. I just was curious, because there's a lot of material here.

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

It is a lot of material, David, you're very right. You're very right.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and David, you're right, there is a lot of material and people have been giving us more and more questions to ask, which is not necessarily helpful.

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

And please don't add anymore.

**Paul Egerman – Businessman/Software Entrepreneur**

Because it's a wonderful thing that these people – look on the screen, these people are willing to participate in our hearing and give us their time, and we don't want to dump 200 questions on them and say, answer all these questions first. Because that's – it's frustrating and also I think less is more, if we really understood some basic concepts here, we probably could do better. One place where we could use a little bit of help, we have a great group of people, is – we are looking for individual patients to also describe their personal experience with this issue. And we have, actually I think, two pretty good leads and possibilities.

It's a tough thing to ask an individual to come forward on something like this, but if people have ideas of individuals who might be willing to testify, who have again had an experience with like a privacy violation, that would be helpful. If you'd let Deven or I know about, you don't want to say the names of anybody on the public call, but if you have any ideas there, that would be helpful, because we think that will help guide us if we can hear directly from one or two people about what their experiences were.

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

This is Gayle, I have a question on providers, do we have any small groups, and I see the Medical Group Management Association, which tends to be some of the smaller groups. Do we have anybody – any of the smaller groups who are – who are willing to really testify as to what their experience has been?

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

We still, I believe, have a smaller community health center that we're trying to nail down. But we did expect MGMA to help us out with the smaller provider perspective. This is another one where getting the right – getting an entity to testify who's very small, where they're probably a little bit less aware of this issue, is a bit of a challenge.

**Paul Egerman – Businessman/Software Entrepreneur**

It's also, Gay – this is Paul, and it's also Gayle interesting. This is an issue where when you get to this concept of usage where in some sense it's easier for the smaller groups. If you picture a solo physician who has a single person as a front desk person and maybe one nurse, in terms of who has access to the EHR within the organization, it's all pretty simple because those three people have access to every record. It gets a lot harder when you're Johns Hopkins or Intermountain Healthcare where you have thousands of people and you try to figure out what the usage issues are. So, I think your point is a good one, but – and hopefully we will be able through MGMA and through the other individual group that we asked, get their feedback also.

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

Um hmm, thank you.

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

All right, anything else before we move to the intermediary issue? The next time we'll all be on the phone together, we actually will be at this hearing, so – all right. Terrific. Thank you all for your feedback, it's very helpful.

Okay, so moving back to the issue of data intermediaries, which we started talking about on our – on a Tiger Team call in August. Just to refresh your memories about how this issue came about, in advance of Stage 3 of the Incentive Program, the Health IT Policy Committee and the Quality Measures Workgroup convened a subgroup, also a Tiger Team, called the Data Intermediary Tiger Team, to make recommendations on data intermediary roles. They were focusing on the use of data intermediaries to facilitate the quality measurement and reporting that is required under the meaningful use program. But there were also, as this Data Intermediary Tiger Team was surfacing its recommendations, questions were asked about privacy and security protections for the data that they would be handling in their role as an intermediary.

The particular Data Intermediary Tiger Team was really looking at certification criteria that would allow these data intermediaries to really serve as a module for the quality reporting aspects of meaningful use. But again, questions were raised about privacy and security aspects of what these data measurement intermediaries might be doing and so we were asked to provide some guidance on this. And we – this issue of privacy and security protections for intermediaries is one that we actually covered in our voluminous, comprehensive letter of September 2010, which also included the recommendations that we made about when meaningful choice is triggered and what meaningful choice looks like.

I think a lot of people don't remember that the very beginning of that letter dealt with data intermediaries and the need for such intermediaries to adopt fair information practices, including collection, use and disclosure limitations, so that the intermediaries are able to use data consistent with the role that they're hired for, but not necessarily in unlimited ways. And that there would be limitations on how long they could retain data, consistent again with the services that they've been hired for. And we focused on our last call, particularly on the recommendations that we had previously made about openness and transparency, where our recommendation was that an entity, which we called a third party service organization. Which is essentially the same as the intermediary in this quality measurement context, that those organizations should be obligated to disclose in their agreements with customers, and customers in this case means the providers that they're serving, how they use and disclose information, including their use and disclosure of de-identified data. And what their retention policies and procedures are and their data security practices. So all of these recommendations that we made back in 2010 about the issue of intermediaries, were adopted by the Policy Committee.

The other thing we did in those recommendations was to acknowledge that currently the business associate agreement, which is required already by HIPAA to be executed between a covered entity, a healthcare provider, and an entity who is receiving protected, identifiable health information to perform a service on that provider's behalf. That the business associate agreement is typically seen as the vehicle for holding these intermediaries accountable for how they handle data. But we acknowledged back then, in September 2010, that it wasn't clear to us that these agreements were necessarily always effective in limiting how intermediaries use or disclose identifiable information. Or in providing the required transparency, in part due to the fact that the – often the business associate is in a place of stronger bargaining position with respect to these agreements. But there also may be other factors in play, including that entities frequently have multiple business associate agreements and it's not always easy to police them for each and every requirement, including the transparency one that we focused on. So at the time in 2010, we thought that perhaps additional work being done on governance might be another way to enforce some of our recommendations on intermediaries.

So again, in our prior discussion on this issue, we again went through what we had said previously on the issue of intermediaries and we also identified that there might be two vehicles – two other vehicles beyond the sort of governance apparatus that we identified in 2010, might be a possible vehicle for holding entities accountable for our recommendations. And that was, was there anything in meaningful use, for example, that we might be able to leverage? Or, there are also some rules that govern intermediaries in a different quality measurement context that are part of CMS rules regarding physician payment policy. And this was something that was mentioned at the very end of the call that we had last time and again, we raise it here as they were sort of placeholders for if – tools to hold entities accountable for the intermediary recommendations, that we had already previously made. But we didn't – they're not offered because we're going to go into detail on this CMS proposed rule on the physician fee schedule. So what did we discuss with respect – oh Paul, were you going to say something, I'm sorry.

**Paul Egerman – Businessman/Software Entrepreneur**

I am, although why don't you continue on this slide before I make my comment.

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

Okay. So when we started talking about what the potential options might be for using Meaningful Use Stage 3 to potentially hold – have a mechanism for holding intermediaries or even their customers, accountable for complying with our recommendations on intermediaries. We discussed an idea of having providers to attest that their business associate agreements with a data intermediary would provide – actually had the recommended provisions regarding transparency about data uses and disclosures of information by the business associate. And we even suggested that perhaps a copy of these transparency provisions could be either submitted or made available to meaningful users as part of the Meaningful Use Program.

Another option we discussed was encouraging providers to rely on their vendors to provide these services, rather than hiring yet another intermediary through a module to do the quality measurement work, thereby cutting down to at least one, the entities that would have access to this data.

**Paul Egerman – Businessman/Software Entrepreneur**

And so, before we go on –

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

Yeah, yes.

**Paul Egerman – Businessman/Software Entrepreneur**

Sorry, going back to the last slide.

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

Sure.

**Paul Egerman – Businessman/Software Entrepreneur**

The comment I wanted to make – oops, is, I think we both hit the previous thing – the comment I wanted to make is on the first bullet. The challenge basically is, when you think about the policy levers that ONC has as a result of HITECH, those policy levers were late to things that the provi – on the provider, like attestation –

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

– so, it's tough to sort of put the burden on the provider when what you really want to do is impact behavior on the part of an intermediary. But we didn't have like a policy lever to deal with the intermediary, so that's sort of like a summary as to what the issue of the first bullet is. The second bullet is sort of like a different concept here, which is to sort of say, maybe the solution here is not to use – to use as few data intermediaries as possible, because the more places you put the data and the more business associate agreements you have, the harder it is.

And what doesn't quite come across in this second bullet, in terms of using the data that's in the EHR system is a lot of these quality reports themselves almost require a separate data model to create. And they're based on concepts involved in the old system of manual record abstraction, where you – people read records and basically right down, this patient has a cardiac problem from reading the record. And if people would define the quality metrics in ways that use the data that's already obtained in the EHR system, then there'd be a greater opportunity to avoid this need for a data intermediary. So, that's the comment in the second bullet.

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

This is John Houston. I think it's going to be difficult in many cases to limit these data intermediaries because of who they are and what they do, and especially when you're going past the quality into some accreditation as well, that's a concern. And the second concern I have, and maybe it's something sort of Deven may have stated it in a different way earlier, a lot of these data intermediaries also are – they try to not – they go past business associate agreements. And some of them require that you sign what almost amounts to a blank data use agreement, as part of the business associate agreement, which gives them broad rights for a variety of uses, including research. So I think there are – there are other things above and beyond just the BAA that is concerning. And again, I think the best example is the fact that they will force you to sign basically a blank check in the form of a data use agreement, which gives them incredible rights above and beyond what a business associate might have rights to.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, and that's an excellent comment, John, appreciate your making that because it speaks to what Deven said a little bit earlier about the – it's like the balance of power that fundamentally. If an organization like UPMC feels that they have no choice but to sign an agreement that they don't really like, then you kind of wonder, well gee, what is like a two-person pediatric group, in terms of, what leverage to they have in signing an agreement. And so it really – that's a valuable comment and I agree that there's a lot of them out there, that this bullet is also a statement that says, well maybe there's a lot of them out there, maybe we don't need to add new ones.

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

Um hmm. Yeah.

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

Gayle –

**Paul Eggerman – Businessman/Software Entrepreneur**

Fundamentally, what we're talking about here is data intermediaries that may be created as a result of reports that might be necessary for Meaningful Use Stage 3. So if we're creating new reporting requirements within meaningful use, it would be nice to create them in such a way that people can actually get it done within the EHR as opposed to creating yet another data intermediary to create the report for the providers.

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

This is Gayle, I'd like to comment on that. Paul, you are so on target. For a small practice, it's extremely difficult if you can't generate the kind of information you need to attest to meaningful use without using an intermediary, you are totally at their mercy. You have no recourse whatsoever and they can use – you basically have to sign away your life in order for them to take you on as a client. And we have no policy leader that allows us legislatively to do anything about it, I think. So, the more you can construct within your EHR or have the measures that we are asking for be attainable through your EHR, the better off most people will be and not being at the total mercy of the various intermediaries out there.

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

So thank you, thank you all of you, those are incredibly helpful comments and are really sort of going back and capturing a lot of the discussion that we had last time, where we also acknowledged that there were circumstances and anecdotal reports that we were hearing and experiences of members of the Tiger Team. That frequently the intermediaries will sometimes reserve for themselves uses of data that don't necessarily match our recommendations, with respect to how that data should be limited when an intermediary receives it and then at minimum, there ought to be transparency about all those data uses. But when we got around to discussing whether it was possible for meaningful use to be a tool for trying to combine this, sort of beyond the point that if in fact the EHRs were certified and the quality measure requirements were done in such a way that they could be reliably generated out of the EHR, that that would lessen the need for an additional intermediary to take on this role.

Aside from that, the issue of sort of trying to have a provider attest to whether its business associate agreements had appropriate limiting provisions and should provide – and transparency language and to potentially provide copies of or make available these provisions, seemed to many of us to be an uncomfortable place for us to go from a recommendation standpoint. And I'm just going to skip the CMS proposed rule for a second. Because essentially what we evaluated even briefly in that context was layering on the same sorts of requirements of, take a look at all your business associates and tell us if they're compliant with these recommendations, especially on transparency and give us copies of the provisions, still runs into the issue that Paul raised, which is, we're putting the onus on the provider. Where what we really want to do is regulate the intermediary, but we don't necessarily have a vehicle for doing that.

So ultimately where Paul and I thought we arrived at the end of our last call on this, was to lay these issues out for the Policy Committee. But ultimately to say we don't think we have a vehicle among the tools that have been offered to date, for trying to hold intermediaries more accountable for being transparent with their customers, the providers or their customers about data uses. And for more rigorously applying fair information practices to the agreements that they enter into and not treating the agreement like a data grab, to put some shorthand on it. So, that's essentially how this conclusion reads. That we found transparency about transparency to be an appealing possibility, but we didn't like necessarily the fact that we were going to – if we were going to use meaningful use or the CMS recommendations, we were going to be essentially asking providers to be accountable for something that we really need the intermediaries themselves to be accountable for. Thoughts on this, I mean –

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

(Indiscernible) – I think you said it all, you put it very succinctly.

**Paul Egerman – Businessman/Software Entrepreneur**

Deven, you also want to talk about those QCDR concepts, make sure that people –

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

Well, so I did skip through the slides, but essentially I – we, the other policy vehicle for potentially getting at the quality data intermediaries is through this – the rules that are part of the physician payment rules that regulate what's called a qualified clinical data registry, which is another entity that can be used for the reporting of quality measures. And there, in the NPRM, they're already proposing that QCDRs enter into business associate agreements. I might argue that HIPAA already requires that, but nevertheless, they've proposed at least that those agreements be entered into. But one of the options that we talked about was maybe looking this as a vehicle for being yet another opportunity to try to get these business associate agreements to have the requisite provisions regarding transparency that we were seeking also to potentially ask providers to attest to as part of meaningful use.

Again, it was the same sort of set of policy recommendations potentially exercised through two different vehicles. But they both suffer from the same deficiencies, which is we're holding the providers ultimately responsible for – through their – we're holding the providers responsible for the QCDR or intermediary behavior, which doesn't ultimately seem like the right thing to do, or even potentially effective.

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

So this is John Houston and I – again, I think back to Paul's point, and I think Deven, even your point. The provider is in an inferior position to negotiate. And again, this goes far past the BAA issue because there can be an overarching agreement again, with data use provisions and research provisions in it that we may be forced to also agree to, which go well above and beyond the intended purpose of the whatever you called, the QCDR.

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

Yeah.

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

And I just hate – they bootstrap everything to something that we're required to do in order to get data, and I don't think we're addressing that – or I think there is something that needs to be done.

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

Yeah, but I'm not sure we can figure out beyond – with the policy vehicles that there, at least that ONC and CMS have at their disposal –

**Paul Egerman – Businessman/Software Entrepreneur**

And we aren't –

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

– that that can really be done.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul again. I'd say, first of all, we are doing something simply by surfacing this discussion. I mean, I think the comments that you made John, the comments that Gayle made, those are valuable comments and we need to make sure that people understand that gee, there's a lot of concern about what's going on with the data intermediaries. And providers like have very little leverage to do anything about it and there's a missing piece here. But beyond that, I don't know what else to suggest, but maybe you do have some ideas John.

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

Why can't we say that the providers shall not be required to submit to additional obligations above and beyond the purpose of this quality organization. Again, if you're – and I'll give you an example. If I had to have surgeons accredited in order for them to continue to perform their specialty, then the accreditation should be what the purpose is and that any additional data grab should not be permitted above and beyond that accreditation service. So, I think that there has to be some way to say, you can't bootstrap to –

**Paul Egerman – Businessman/Software Entrepreneur**

That would be an interesting recommendation, I think, would be to say, if somebody has a certified EHR, the concept should be that the EHR should do everything. And that the – as a consequence of having a certified EHR, the provider should not be required to use a data intermediary to produce any quality report required by ONC for meaningful use or required by CMS for any of its incentive programs. Now they could still – in other words, providers might still use data intermediaries because there are other reasons to use them, because maybe it's convenient, but then it becomes a little bit more of a matter of choice.

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

But a lot of those – go beyond what you – the use case you just –

**Paul Egerman – Businessman/Software Entrepreneur**

Right, I know but I'm just saying, if you look at ONC and CMS, at least that's within the scope of what our recommendations are. I mean, you get to accreditation, that's outside of anything I think that we can influence.

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

And maybe I'm just so fixated on that as being an issue that I'm looking beyond the bounds of –

**Paul Egerman – Businessman/Software Entrepreneur**

Well –

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

I apologize.

**Paul Egerman – Businessman/Software Entrepreneur**

Let me just say, CMS is usually influential – impactful on things, I mean, if CMS takes a position on something, a lot of other things sort of fall in place.

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

And when they do accreditation at times, they say, hey, we need to have pure data in order to do the accreditation type of activities and therefore having the EHR perform that function may not be sufficient because the EHR lacks pure data from the industry that's necessary in order to accomplish the accreditation activities.

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

Well, and this is David. I think there – even in a more limited space of quality metrics, it's not out of the question that some of the Stage 3 quality metrics would require data that exists outside the EHR, therefore you'd have to have an intermediary pull it together.

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

I agree.

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

Outcomes data, patient-generated outcomes and connection between the hospital and –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, but the intermediary does not necessarily have to have what I call the raw patient data to pull it together.

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

No, I agree, I'm just saying that –

**Paul Egerman – Businessman/Software Entrepreneur**

You know, you could do both for the quality purpose and also for the purpose that John describes, a system where you provide aggregate data to an intermediary, right, where you sort of say this is our infection rate, we had...

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

Well, but it's –

**Paul Egerman – Businessman/Software Entrepreneur**

– this number of central line patients, this number of infections and then somebody takes that and then puts it in and says, okay, you're in the 32<sup>nd</sup> percentile.

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

But if – Paul, if the quality metric requires correlation of actual patients experience, outcomes two years after their procedure or something like that, it can't be done within the EHR unless the EHR itself becomes the intermediary and has the outside systems send it in. Which just – so all I'm saying is I think in the current quality measures for meaningful use, they all could be done within the EHR, that's what we do, but I bet you there are emerging quality metrics where that won't be true anymore and you'll have to integrate patient specific data in an intermediary.

**Paul Egerman – Businessman/Software Entrepreneur**

But is it feasible to do what I'm suggesting, to say, well if there's emerging quality metrics, they should be created with this lens of what's in the EHR.

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

Well you – yeah, you could limit it to that, I just think that'll –

**Paul Egerman – Businessman/Software Entrepreneur**

And would that limit the usability of them? I mean, that's the part I don't understand.

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

Paul –

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

Well, I think it limits the long-range quality metrics that are focused on outcome as opposed to process, which there's a lot of pressure to switch to outcome –

**Paul Egerman – Businessman/Software Entrepreneur**

Oh, but doesn't that maybe that suggests the EHR needs to evolve for that to occur.

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

So I have a couple of thoughts on this. One is that a recommendation that urges the Policy Committee and the Standards Committee for that matter, as a matter of certification, to be mindful that we shouldn't be asking for physicians to be producing things for meaningful use quality reporting that essentially require them to hire additional intermediaries beyond their EHR vendor, which itself is an intermediary, in order to get that done. I don't think it's necessarily a bad thing to make that point. But I think we also have to keep in mind that the EHR vendor itself is also an intermediary that ought to be –

**Paul Egerman – Businessman/Software Entrepreneur**

I don't agree that the EHR vendors necessarily a data intermediary.

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

We considered at the – sorry, I need to deflect a call that’s coming in – we, at the time that we did our 2010 letter, we didn’t use the term intermediary, we used the terms third party service organization, which was defined very broadly as an entity that provided assistance in exchanging data for healthcare providers. And so, certainly a vendor needs to actually execute a business associate agreement, that would make –

**Paul Egerman – Businessman/Software Entrepreneur**

Well sure, they’re business associates, but a data intermediary, in my view, is somebody who actually somehow within their four walls ends up with patient data that – and they’re not a covered entity. And so that’s not necessarily a vendor, I mean, some vendors do have the data, if they’re doing like cloud computing or something –

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

I wasn’t suggesting –

**Paul Egerman – Businessman/Software Entrepreneur**

– but David McCallie on the phone and I think a fair amount of the way Cerner operates, the data resides with the healthcare provider and I don’t see Cerner being a data intermediary in that environment.

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

Well, although, I mean, the vast majority of our new business is cloud-based –

**Paul Egerman – Businessman/Software Entrepreneur**

And so the cloud-based is a little bit different, but –

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

Well and –

**Paul Egerman – Businessman/Software Entrepreneur**

– I mean, I believe UPMC is one of your customers –

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

– and they control their own data and they –

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– it’s not like Cerner can choose to do something with the data, because they don’t have direct access to it.

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

I think all I’m suggesting is that our recommendations, when we initially made them, really fell to – were about sort of organizations that would hold data, which would be EHR vendors in some instances, but not in all –

**Paul Egerman – Businessman/Software Entrepreneur**

(Indiscernible)

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

– I think a recommendation that says just to have it all be done by the EHR vendor doesn’t necessarily get you out of some of the issues that we’ve raised.

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, but again, what I'm saying is, when it's done by the EHR system it's not required that an additional data intermediary –

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– be used. And I'm sort of resistant to the whole idea that the EHR vendor is necessarily a data intermediary, because I don't think they are –

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

No.

**Paul Egerman – Businessman/Software Entrepreneur**

I think they might be, but they might not be and you could have situations then, so that an organization like UPMC could, in effect, to the extent possible, keep the data within their own four walls, if that's what they wanted to do. And you kind of shrug your shoulders and say, well, that's great privacy and security because you know who's got the data and you know who's responsible for it.

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

Yeah, but – and this is David, I think that's true in some circumstances, but I think Deven's point is that even if you were able to achieve that with respect to some of the quality metrics, there are other cases, such as John's example of accreditation –

**Paul Egerman – Businessman/Software Entrepreneur**

Well yeah, oh, I agree with that, I'm just sort of saying, at least within the ONC program, let's not add a requirement for new quality – for new data intermediaries and –

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

Yeah, I –

**Paul Egerman – Businessman/Software Entrepreneur**

– and I'm asking the question, is it possible to make a recommendation that even more broadly, minimizes the need for data intermediaries and perhaps shrinks the number of data intermediaries over time. It's like you can't get rid of them right away, but is such a recommendation possible or am I being to –

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

I think with the emergence of the focus on population health, we're going to see more of them, not less of them. And some of the population health companies will, in fact, provide your quality measures for you as a benefit of the quality – of the population health, because they need the quality measures to feed back to the physicians to let them know how they're doing towards their quality metrics. So, I don't think that the intermediary problem is going to go away simply by –

**M**

I agree.

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

Especially if we go into deeming and people are able to deem –

**Paul Egerman – Businessman/Software Entrepreneur**

Gayle, can you speak up, I'm having trouble hearing you.

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

Yes, I think as we go into the use of deeming as a way of qualifying for meaningful use, you're going to have even more intermediaries.

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

So this is Joy and this has been a very interesting conversation. And the last piece of this discussion to me seems like it's something that you really need to discuss further with Quality Measures Workgroup in much more detail, to see what their expectations are here and what kind of measures they want and what would be feasible from a technology standpoint via an EHR versus an intermediary.

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

In other words Joy, before we would say definitively that there ought to be steps taken to minimize intermediaries in the quality measurement context?

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

I think that, when I'm listening to this, I know how sensitive the Tiger Team is when other workgroups kind of start getting into their territory and I just get a little concerned that we may be venturing into the Quality Measures Workgroup's territory a little bit. And I surely understand and appreciate the issue, and I'm just trying to think of a way of phrasing it so that we respect their boundaries.

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

So what if rather than – I mean we already do make note that it is the case that if we were to structure the measurement program in a way that additional capabilities would need to be hired, that extends the number of intermediaries that could potentially be required versus keeping them – I mean, we talked about that. But ultimately not making a recommendation to expressly limit intermediaries, but – people should have the functionalities as part of CEHRT that they need in order to achieve meaningful use, that's really sort of the bottom line.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, that's right. And so I listened to what Joy said, which was very helpful, and maybe on this topic instead of making a recommendation to limit the data intermediaries or to limit how quality metrics are defined, we put forward a question that sort of says, from a privacy and security standpoint, here's how we view the situation, a question to the quality team and to ONC is, is it possible to write the quality metrics in such a way that data intermediaries will not be required or new ones will not be required?

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Paul, I think the focusing on highlighting the privacy and security concerns of – from a privacy and security perspective, this is where we think a line should be drawn. Versus a recommendation that we would expect the Policy Committee to make to me seems like a rational approach and one that may be a little bit more within the lines of what they were expecting to get from the team.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay.

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

Joy, I'm sorry, Joy, I missed that first part, what did you say? Could you just repeat briefly what you just said?

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Idea is already gone John, so I'm not sure if I could get it back again. But I think that the – if you phrase this in terms of from a privacy and security perspective, we would recommend approaching this issue in a manner that reduces the amount of data intermediaries for the following reasons is kind of – I think that works really well, because that's within your parameters. But I think ultimately the balancing of that – I'm going to change a little bit what I said is, a little bit may need to take into account other factors and that the Policy Committee may be – you're saying, "I'd like you to consider this" is different than, "we think you should recommend it."

**M**

Okay.

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Does that make sense?

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

Yes.

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

This is David. That makes sense, but I don't think it addresses John's original fear or experience that the data intermediaries that are necessary, and there will be some for sure, have the power to compel uses of the data that go beyond the specific service they were hired to do. And they have a market position where they can enforce that –

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

Yeah, but –

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

– and that's – so we just –

**Paul Egerman – Businessman/Software Entrepreneur**

And so how do we capture that? I mean, is it adequate to capture that by trying to summarize the conversation we had on this thing, especially that there's a lot of concern about this as it relates to, I don't know, balance of powers –

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

I will tell you that from our perspective, this has been a hard issue to address because we've had a difficult time getting anybody to really – to get what I would call concrete evidence of this on the record.

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

Really, I wish I'd have been on the record then because I could give you examples probably once a month when this comes up.

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Well you know, that would – I think that that would be very useful to get some more of this on the record. I mean having one – John, I think it would be great if you would be ready to do it, name names and say what your experience has been. Because this is an issue that we have looked at and we have heard about kind of anecdotally off the record, but it has been kind of difficult to get some people – to get many people to actually say anything on the record because of, I'm guessing, because there's a little bit of fear of retribution involved.

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

Sure. I'll give you a great example. Last week I reviewed a con – an agreement that – the title of the agreement was, Business Associate and Data Use Agreement. That was then name of it and they were forcing us into a business associate agreement with a data use terms attached to it, which specified that they could use it for unnamed future research, the data. So, I – this happens.

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Oh, I believe it happens. Like I said, it's just been hard for us to get it –

**Paul Egerman – Businessman/Software Entrepreneur**

Yup, and also to be, in my mind, to be clear there are two different problems. One is the problem that John is talking about which is how these – how the data is used, which is troubling, very troubling. The second problem that I'd like to make – point out from privacy and security standpoint is just a very simple concept, which is, the more places that you physically put a patient's data, the more copies there are, the higher and the probability is that you're going to have a problem sooner or later.

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

Yup.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, I mean, just again, using UPMC as an example, but if I were a patient at UPMC and UPMC was the only place where my data was, well then it's very clear to me where the data is and who's responsible for it.

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

Well, I think you need to –

**Paul Egerman – Businessman/Software Entrepreneur**

But if my data is at 20 or 30 different places, then there are 20 or 30 times greater probability, perhaps more, that something's going to go wrong.

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

Right, I think there's, above and beyond that, and this gets a little philosophical, there are arguments about even if the data is protected and only used for things as described within these agreements, should the patient have the right to decide or not to decide whether that's a use that they want their data to be used for –

**Paul Egerman – Businessman/Software Entrepreneur**

Well, that's true –

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

– whether it remains secure or not. This is sort of an idea of sort of – what's the word, a notion of – I'm forgetting the term, but it's

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Autonomy?

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

Excuse me?

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

Is it autonomy?

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

Yes, thank you, I couldn't think of the word. Thank you, it's sort of the patient autonomy, how much right should the patient have over his or her information, and in what form, even if it has been partially de-identified, how much rights do they have to that data?

**Paul Egerman – Businessman/Software Entrepreneur**

That's a good point.

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

Well, if that's – with all due respect John, as much as I love having that conversation, it's a little bigger than the one that's in front of us right now.

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

I know, I know, I know, and I should probably keep it at the hard – the issue that's really most – that's easy to discuss and doesn't get very philosophical, but patient autonomy is still a big concern out of people.

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

Absolutely.

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

Well you have to – I'll – to that.

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

Yeah. What it sounds like we need to do is to essentially tee these – this set of issues up to the Policy Committee, including, per Joy's suggestion, the comment about how certainly from a privacy and security approach, when you're using fewer intermediaries to get a job done, that reduces the risk to privacy and security. So to the extent that we're sort of contemplating additional measures, we should be mindful of what that means, from a privacy and security standpoint, in terms of increasing the number of persons and entities who have access to this data, and thereby potentially exacerbating some concerns that we've heard. But that we explore – gave consideration to having providers to attest to this as part of meaningful use or as part of engagement of CDRs for quality reporting in another context.

And it just felt like we were not aiming policy recommendations in the right place and so we were not – we're sort of left with teeing these issues up as ones we need to continue to monitor, wishing we had a better vehicle for accountability. But this is the sort of scenario that we have. So, articulated hopefully a bit better than that, but along those general themes, does that sound acceptable in terms of how we present this to the Policy Committee? So that we have done our job and raised our concerns, all legitimate, but unfortunately with this one we don't have a do X, Y and Z and all of this will be fixed set of recommendations.

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

Deven, this is David. I liked Paul's comment earlier that the mere fact that we're discussing these issues is important and becomes something to attract attention. My – so I like what you summarized there, as long as it's clear that we're not just talking about quality, but we're talking about the broader, unintended uses of data obtained under business associate agreement where there's – that may not, in fact, serve the purpose specifically of the need for the agreement, but go beyond that, but are coerced on. I mean quality measures would create another target for that kind of thing to happen, but our broader concern is the broad concern that John raised, and as long as it's captured that way.

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

Yeah.

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

Okay.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, that's a fair comment. Because if it's not – it's almost like we're singling out quality –

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

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

– and there's a lot of other things that happen, these issues relate to HIE organizations, they relate to a lot of different things that are going on.

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

It relates to almost any organization that has this third party that has some ability to influence – unduly influence the provider, in a way, does somewhat almost compel their participation, if that makes sense.

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

Yeah, any kind of asymmetry of decision – of power in the decision.

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

Exactly.

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

It could go either way, of course.

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

Yeah, but the covered entity – the provider still is the covered entity, so it in theory should be in the position to have the most control over that, but –

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

Yeah, yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

So we should bring in the FTC here somehow, as you have monopolistic concerns about some of these accreditation issues. They represent – localized monopoly.

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

Don't get me started.

**Paul Egerman – Businessman/Software Entrepreneur**

Would be an interesting discussion.

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

As much as I would love to stay for the rest of this conversation, this is Joy and I have to present at a 3 o'clock meeting so I have to drop off.

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

Okay.

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

Very – Joy.

**Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator**

We're okay?

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

Yup, I believe we are, we'll write this up and circulate it for – to make sure we've wordsmithed it correctly, but I think we're teeing up this issue I agree is important, and we're going to.

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

Hey Deven, this is Larry Garber. I've been silently lurking on the call and listening and I agree with everything you're doing. I just wanted to thank you.

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

Oh thank you Larry. So just for those of you who haven't had a chance to meet Larry, we have his participation on the Tiger Team. He's very kindly agreed to serve on the team in addition to continuing his service on the Information Exchange Workgroup, because with Neil Calman resigning from the Tiger Team, we have not had a physician – practicing physician input for quite some time. So Larry, it's great to have you. You'll also help us to achieve some continuity with our recommendations and those of the IE Workgroup. So thank you.

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

Sure. And I really appreciate that you didn't throw the burden on the physicians about getting all this done, so thank you.

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

Any other thoughts before we – we might actually be able to close up a bit early today.

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

I think it's all good, I think this is great dialogue.

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

Yeah, no –

**Paul Egerman – Businessman/Software Entrepreneur**

It is a great discussion.

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

Really good discussion. Great. Michelle, you want to take us to public comment?

## **Public Comment**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Deven. Operator, can you open the lines?

**Ashley Griffin – Management Assistant – Altarum Institute**

If you are on the phone and would like to make a public comment, please press \*1 at this time. 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. We have no public comments at this time.

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

All right. Thank you all very much and –

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

Thank you.

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

– we will –

**Paul Egerman – Businessman/Software Entrepreneur**

We will hear from you on September 30.

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

I almost said see, and I realized that was not right. Thanks a lot.

**Paul Egerman – Businessman/Software Entrepreneur**

Take care.