

New York eHealth Collaborative Policy Committee Meeting
September 29, 2020
2 p.m. – 4 p.m.
Meeting Notes

A meeting of the NYeC Policy Committee was held on September 29, 2020. Present via telephone were:

Art Levin, Center for Medical Consumers, Chair of Policy Committee
Nance Shatzkin, Bronx RHIO
Steve Allen, HealthLink
Amy Warner, Rochester RHIO
Karen Romano, HealthConnections
Tajymoor Naqi, Hixny
Todd Rogow, Healthix
James Kirkwood, NYS DOH
Jonathan Karmel, NYS DOH
Deirdre Depew, NYS DOH
Dan Schiller, NYS DOH
Geraldine Johnson, NYS DOH
Molly Finnerty, NYS OMH
Carmen Barber, NYS OMH
Tammy Harris, OPWDD
Jen Freeman, OPWDD
Laurie Pferr, Office for the Aging
David Lee, New York City Department of Health and Mental Hygiene
Dr. Tom Mahoney, Common Ground Health
Dr. Glenn Martin, Queens Health Network
Dr. David Cohen, Maimonides Medical Center
Zeynep Sumer King, GNYHA
Puja Khare, GNYHA
Jill Eisenstein, BOC Representative
Chuck Bell, Consumer Reports
Val Grey, NYeC
Cindy Sutliff, NYeC
Nate Donnelly, NYeC
Zoe Barber, NYeC
Alexandra Fitz Blais, NYeC
Toby Lewis, NYeC
Sam Roods, NYeC
Bob Belfort, Manatt
Alex Dworkowitz, Manatt

The meeting was called to order by Mr. Levin at 2 p.m.

I. Welcome and Introductions

Mr. Levin welcomed the Committee members and provided a brief biography of Alan Cohen, the newest board member. He introduced Mr. Kirkwood to provide an update.

II. DOH Update

Mr. Kirkwood described DOH's continuing work related to COVID-19 contact tracing. He said DOH was also looking at different public health use cases using FHIR, and they were developing more specifics on the data elements actually needed.

III. Executive Director Update

Ms. Grey said the state was continuing to face financial pressures with a \$15 billion deficit. She said while there is movement on a federal stimulus package, the new HEROES legislation cuts state and local relief by half, which is not good news.

Ms. Grey explained that NYeC was continuing to work on interpreting the information blocking rule as it applies to the SHIN-NY. On the CMS said, she said that they were working to make sure that the SHIN-NY is prepared to fulfill some of the requirements on behalf of hospitals.

IV. Telehealth and SHIN-NY Policies

Mr. Dworkowitz described the different policy options regarding the duration of a verbal telehealth consent. Mr. Allen asked about the treatment of data under the mental hygiene law. Mr. Barber explained that OMH's position was that they prefer a digital signature, not verbal consent alone, once the emergency ends. Dr. Martin said that since this interpretation was not required by statute but was policy, OMH should bring it before the behavioral health advisory council for discussion.

Mr. Levin asked what the Committee thought about the three options on duration of a verbal consent. Dr. Martin suggested that the protections in the first option should be incorporated into the second option regarding consent lasting for an episode of care. Mr. Allen said he preferred the third option – a 72-hour duration – since it was simple. Mr. Naqi said the only option that doesn't disrupt patient care is the first option, which allows consent to persist indefinitely. Ms. Eisenstein said the BOC was split on the options.

Dr. Martin said the second option tracks most closely with what is currently occurring and it was his preference. Dr. Cohen agreed. Dr. Mahoney said it would be a step backward not to allow consent to be provided verbally.

Mr. Naqi said 98% of patients decide to give consent via Hixny. He said if a patient has previously given a physician verbal consent, that physician should be able to check the patient's records prior to their next encounter, and the proposed 3-month limit under the second option would interfere with this. Ms. Finnerty said they need to be forward looking and think about where they want to be in five years, and she liked the first option since that is the future.

Ms. Shatzkin asked if the verbal consent would apply to when the patient went to the office? Mr. Belfort said it was clear that the episode of care concept is confusing. He said if verbal consent is less trustworthy then there is a rationale for putting a limit on its use. He suggested they allow verbal consent to continue until a patient comes into an office, a policy that would allow telehealth to continue but wouldn't allow the consent to last indefinitely. Ms. Warner and Dr. Martin agreed with such an approach.

Ms. Sutliff said it seemed like most people were leaning toward the second option with certain modifications. She said that the proposed language would be revised and discussed at the October committee meeting where it could be finalized.

V. Patient Apps

Mr. Dworkowitz provided an overview of proposed principles for the sharing of data with patient-held apps. He asked several questions of the Committee members relevant to developing policies for such apps, including regarding the form of patient education about such apps.

Mr. Bell said he thought patient education was a great idea, and he was happy to volunteer to brainstorm ideas about what could be done. He said he worried that the field of patient education would be under resourced.

Mr. Allen said he was very concerned about the education piece. He said he did not think it should be left up to each QE to do its own process, since one QE would choose to educate one way and another could do something that would contradict the first QE. Ms. Sutliff agreed it should be a SHIN-NY wide education, but noted it was still important to have a policy regarding education. Mr. Belfort said it was important to leverage neutral standards setting organizations, since the apps would change every week and it should not be the responsibility of QEs to make case-by-case judgments.

Mr. Levin asked if there any standards for apps other than those developed by the Carin Alliance. Mr. Donnelly said that the Medicare Blue Button initiative also vets apps.

Ms. Shatzkin said it should be the apps who are responsible for engaging in identity proofing, and the QEs should not be responsible for doing identity proofing alone. Ms. Sutliff said it was important that the QE knows that the person claiming to be the patient is who they say they are.

Mr. Levin said they would continue this discussion at the next meeting.

VI. Section 1.2.10 Recommendations

Mr. Donnelly explained that Section 1.2.10 had been added to the SHIN-NY policies a couple of years ago to allow for medical record review under DSRIP. He noted the same issue comes up with NCQA and HEDIS reporting, and therefore DOH felt the provision should not be limited to

Medicaid but should be expanded to other payers. He said it would be limited to purposes of medical record reviews for core HEDIS and NCQA determinations, and disclosures could not be made for any other purpose.

Mr. Allen asked if QEs would be providing patient records to payers for these purposes without consent. Mr. Donnelly responded that yes, disclosure could be made without consent in such a case.

Mr. Levin asked if there was consensus on the proposal. Hearing no objection, he said the proposal would move forward.

VII. Closing

Mr. Levin thanked the Committee and adjourned the meeting. Ms. Sutliff said the next meeting would be a 4-hour discussion on October 22.