Patient Information Blocking and Patient Tracking Technologies

Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight [00:09:30] Health. It is Thursday, November 16th. Thanksgiving is a week away. It's one of my favorite holidays because I really don't have to do anything. I just have to make it to my sister-in-Law's house to watch football and eat dinner. I think I could manage that, but can we effectively manage protected health information? There's your transition. If you missed it, we're going to talk about PHI and two contexts today with Dave Johnson, founder and CEO 4sight Health, [00:10:00] and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How are you guys doing this morning, Dave?

Well, how could I not be doing great? Julie and I were on stage together in Washington, DC earlier this week at the annual meeting of the National Alliance of Healthcare Purchasing coalitions.

It wasn't exactly taking the roundup on the road, [00:20:00] which we should do sometime, but it was definitely the very best next thing.

Good to hear that you guys got together. Thanks, Julie. How are you?

Julie Murchinson: (20:10):

It was really fun to be on stage with Dave, so thank you, Dave. That was great. And I then immediately went to Phoenix for the first in-person, behavioral health tech conference that SOL May has put on, and it is like the center of gravity for [00:20:30] everyone on the health plan side primarily, and innovators and policy makers who care about behavioral health. I mean, it's quite a thing. So I encourage everyone to check it out next year.

sounds really impressive. Very cool. Now before we talk protected health information, let's complete our previous conversation about Thanksgiving. Dave, we know you don't eat Turkey. We know you don't eat pumpkin pie, and we do know that you're running [00:21:00] in a Turkey trott. So my question is, how are you going to spend Black Friday raking leaves, putting up holiday decorations or shopping,

David W. Johnson: (21:10):

Eating leftover pecan pie? None of the above. Dave. I've got a book manuscript to finish by the end of the year, so I'll be chained to my desk on Black Friday writing away. It's a good thing. I like to write.

David Burda: (21:27):

Gets you out of a lot of stuff.

Good for you. Julie, what are your Black Friday plans after eating pumpkin pie and also running in a Turkey trott.

Julie Murchinson: (21:38):

Oh my gosh. I hope I'm sleeping in and going to the beach and not buying another thing I don't need.

David Burda: (21:46):

Yeah, a lot of packages piling up at the front door.

Well, I'm definitely not running in a Turkey trott, but I will burn off some Thanksgiving calories by raking leaves, putting up decorations or both. So Dave, you're [00:22:00] going to be writing, I'm going to be praying for rain.

Okay. Let's talk about protected health information in two contexts today. The first is information blocking, and that's when a provider quote, knowingly and unreasonably interferes with the access exchange or use of electronic health information. [00:05:00] HHS proposed penalties for providers who information block the penalties include a cut in Medicare payment rates for hospitals, a zero interoperability score for physicians who participate in the MIPS program. So I guess that would reduce their Medicare payment rates and getting kicked out of an accountable care organization if you're in an ACO.

The second context is the American Hospital Association's federal lawsuit against [00:05:30] HHS. The AHA is challenging a new rule. The rule bars, HIPAA covered entities like hospitals to use online tracking technologies to capture data from patients who visit their websites or use their mobile apps. HHS says, protected health information to obtain through tracking technology could be misused to promote misinformation, identity theft, stalking, and harassment. Ouch. The AHA says the rule is counterproductive. [00:06:00] It hurts hospital's ability to collect and share health information with communities, improve their websites and apps, and improve public health.

Dave, let me ask you about the first context penalties for information blocking. What's your reaction to what HHS is proposing? Do you think they're strong enough to stop information blocking and do they get us closer to interoperability? [00:22:30] Nirvana?

David W. Johnson: (22:32):

Let's go to the last question first. There's a long way to go, unfortunately, to reach interoperability Nirvana. I think we discussed the class report that issued in March that gave grades to the EHR big EHR companies based on 180 interviews of EHR users,

David Burda: (22:58):

Right? Remember

David W. Johnson: (22:59):

That? [00:23:00] You remember that? And the grades weren't great. Epic got AB minus Oracle. Cerner got AC plus and Meditech, A-K-A-H-C-A got AC minus on this basis. Epic appears to be a good speller in a bad row. Becker's said as much last month in a long article, particularly long for Becker's, since most of their things are like one or two paragraphs detailing how [00:23:30] Epic has won over all the academic medical centers to their EHR. The punchline of their analysis or the conclusion was that integration trumps interoperability. In other words, it's better to be inside Epic's walled garden to share information with other epic users than on the outside looking in. That explains why Epic seems to be winning all of the head-to-head [00:24:00] competitions with Oracle. Cerner. I was with Rich Lemoine from Sharp last weekend, and he told me that Sharp is in the process of converting to Epic from Cerner this fall, another big system falling into Epic's camp.

(24:20):

They're really increasingly becoming the only game in town. But make no mistake, that's a long way from O C's goal of having all necessary patient data available to all relevant providers to enhance their medical decision-making capabilities. My reaction to the penalties, your first question is that there a step in the right direction, [00:25:00] enforcement and the magnitude of the penalties and their impact will determine their ultimate effectiveness. But stepping back, it just saddens me that providers don't embrace interoperability because it's the right thing to do for their patients and for the American people.

It's the difference between having to do something and wanting to do something, having to do something because the rules say you do and wanting to do something because you believe in it. To use a sports metaphor, it's like the Houston Astros or the New England Patriots who cared more about winning than playing by the rules they got caught, but still retain their championships. Of course, healthcare is far more important than sports, [00:26:00] and yet Epic certainly plays to win whatever it takes. They've fought the interoperability rules

with every fiber of their corporate being since their inception, and they continue to do so. As we've discussed many times here on the roundup, the Epic tools are far from perfect. They're expensive. They use antiquated programming language. They're hard to use. They emphasize billing first. They [00:26:30] contribute significantly to caregiver burnout.

(26:34):

Yet, yet, despite all that, we can't give up. We just can't give up on the goal of full interoperability. ONC needs keep up the good fight. Maybe the Justice Department and or the FDC need to get involved, but most importantly, the industry needs payment models that reward outcomes. We don't need payment models that continue to incentivize over billing and overtreatment [00:27:00] until we get payment aligned with outcomes. Providers may be doing EHR data exchange, right? To optimize their performance, but they won't be doing the right thing for the American people. Doing it right means following the rules, doing the right thing requires a moral compass, and we just don't have enough of that moral compass governing our behavior [00:27:30] in the healthcare industry today. Not even close.

David Burda: (27:33):

Yeah, following the letter of the law versus the spirit of the law.

Julie. Any questions for Dave?

Julie Murchinson: (27:42):

Well, I guess I have a question about another potential driver. It's been seven years since the 21st Century Cures Act passed, and this time last year, providers were still communicating that they weren't ready. So there, it's been a long time, and I saw something in [00:28:00] all of this about a wall of shame where OMC plans to publish the names of the actors that are found guilty of information blocking and any penalties they received. Did you read anywhere whether that's made it through, and do you think that could be powerful incentive for providers,

Walls of shame or [00:29:30] shaming have been a part of American culture going all the way back to the beginning. Nathaniel Hawthorne's book, the Scarlet Letter, wrote about social mores and early

puritan communities in the Massachusetts Bay Colony. We have a wall of shame with pictures right down the street from us at Chub, AUB flub for anyone who puts ketchup on their hot dogs.

David Burda: (29:59):

That's a very Chicago [00:30:00] thing. Yes, I'm sorry. Yeah,

David W. Johnson: (30:01):

It's a very Chicago thing. Yelp has one for companies caught paying for fake reviews, but more seriously, HHS has a legislatively mandated wall of shame from the high tech TAC for HIPAA violations. Julie, I looked long and hard, but couldn't find an equivalent wall of shame for information blocking. I saw a few references to it here and there, but given the lack of compliance [00:30:30] with and the extent of information blocking, maybe we should have one.

Julie Murchinson: (30:39):

You can start one.

I was in the store in Duluth with my wife. This is about three or four weeks ago, and there were pictures of known shoplifters right when you walk in the door right above the register. And all it did was made [00:31:00] me afraid to touch anything. So we spent about 15 seconds and got out of there. Not like I was playing you to steal anything, but it was

David W. Johnson: (31:14):

Deterring the

David Burda: (31:15):

Vehicle. Well, the first thing you do is I started to look at the people to see if pay. Are they in here? Then I got scared and left. So there you go.

Julie Murchinson: (31:25):

AlBurda

David W. Johnson: (31:26):

Deterring the wrong people. Right?

David Burda: (31:28):

There we go. Yeah. I'm living

Julie Murchinson: (31:29):

A life of [00:31:30] sphere,

David Burda: (31:30):

Right? Yeah, I was ready to buy something. All right, thanks Dave. Julie, let me ask you about the second context, the rule against tracking technologies. What do you think about HH S'S rule? What do you think about the ah ha's arguments and how do both affect the market for developing new digital health technologies and apps?

Julie Murchinson: (31:53):

Well, I really looked at this through the lens of HIPAA and its shortcomings. I mean, it's almost three decades old. It's almost [00:32:00] entirely obsolete and riddled with technology induced gaps. It was created, remember 10 years, even more me before iPhones were invented. So it hasn't caught up with the pace of change of technology, and it's left vast amounts of sensitive data outside the scope of hipaa. For example, the loft fails to contemplate smartphone-based healthcare apps and digital health websites. [00:32:30] And our friend Bob Kocher says it's like cars before seat belts.

The CEO of standard care said it really well. He said, people think of HIPAA as the federal government protecting my healthcare. What it actually is, is an umbrella made of concrete with gaping holes in it, which is kind of a good visual.

David Burda: (33:00):

[00:33:00] That's great.

Julie Murchinson: (33:01):

So since regulators and politicians seem unwilling to address shortcomings of hipaa, the private market is doing what the private market does, which is I think moving towards a fix. And what's going on with these tracking technologies is AI powered algorithms are gathering data from all sorts of sites, social media, web searches, phone use, et cetera. And this happens in a ton of industries. [00:33:30] And the issue here is what information can be used against a person in a way that could harm them? And most consumers don't distinguish between a message they send to their hospital provider. That is likely HIPAA protected in some EHR portal and one that's sent over a digital health app, which is not necessarily protected by hipaa. And University of Pennsylvania study found that 99% [00:34:00] of hospital websites are allowing third party tracking software. And why are they doing this? They're doing this because we're all encouraging helping hospitals and health systems see that they need to compete for patients, they need to compete in their markets, and that requires intelligence.

(34:20):

These hospitals are just doing what many other businesses in normal economic environments do, which [00:34:30] is collecting intelligence so that they can use that for marketing or they can use that for business operations. And the technologies these hospitals are using are not all evil or inappropriate, but the data protections are or could be insufficient to do the right thing. So honestly, the private markets may need to develop mechanisms outside of HIPAA to protect health data as an asset, given where the feds are, [00:35:00] we can't have our cake and eat it too, around building a different healthcare economy and living in these old structures.

David Burda: (35:09):

We always argue for personalization, right? And then that's hard to do if you can't collect the data. No, impossible is not. No. Thanks, Julie. Dave, any questions for Julie?

David W. Johnson: Here we are approaching the one year anniversary of the November 30th launch of GPT. And so much has [00:36:00] happened since then with generative AI technologies.

Is the development of advanced data technologies [00:36:30] occurring too fast for regulators to keep up, particularly given all the parochial interests, including what providers want that use their political leverage to delay implementation? Is it possible, like you were describing with hipaa, that the marketplace will achieve true data interoperability before regulators can create rules to guarantee the same thing?

Julie Murchinson: (37:00):

[00:37:00] Yeah, I mean, I think it's already happening. And in spots that's the problem. So we're creating new spots of interoperability that are very consumer-centric, and there have been a lot of movements over the years to really try to help provide patient control of all their data in ways that create interoperability that's controlled by that patient, which is actually [00:37:30] the line share of what is important and can actually help facilitate some of the administrative efficiencies as well. So I do think technology's moving too fast. I don't know that chat GBT is going to be a driver for interoperability. I think it's going to fall more on the risk side of everything that we just talked about, but I don't see how the regulators [00:38:00] can do much more. That doesn't seem draconian.

David Burda: (38:05):

I do think it all comes down to intent. Are you blocking or not blocking health information for the good of the patient? Are you tracking or not tracking health information for the good of the patient? And it's impossible to regulate intent. So we'll see how this one plays out. Great discussion. Now let's talk about other [00:38:30] big news that happened this week, Julie. What else happened that we should know about?

Julie Murchinson: (38:35):

Well, president Biden announced the first ever White House initiative on women's health research, and the First lady, Jill Biden's going to lead that. And it's important for a whole host of reasons. But what I think is we are, as we've talked about here, starting to really see segmentation in the market as innovators come in and develop solutions [00:39:00] for women's health or solutions for certain ethnicities or L-G-B-T-Q, or really getting down into this personalization burden that you mentioned, and to actually have a research effort come along at this time for the broader catchment of women, I think is great. It's a great important step to marrying where we are in these worlds

David Burda: (39:26):

Here here. I agree. Dave, what other news caught your attention [00:39:30] this week?

Not only were Julie and I together on Tuesday, we were together last Friday evening in Laguna Beach for Gary bis memorial service, which was a wonderful event. Gary was the co-founder of the Health Management Academy, and died eight months to the day last Friday of his memorial [00:40:00] service. And the whole evening was just a testament to the power of community building and the synergistic effects that come from being able to bring people together in trusted environments over a long period of time to work together to solve problems. So Gary's tribute really is in, or his legacy, I think resides in all of the connections that he helped to foster and [00:40:30] have helped move the industry forward. So kudos to Gary and everything he was able to accomplish.

David Burda: (40:37):

Yeah, I learned a lot from him and he was always very patient with me when I asked questions. So yeah, I miss him. A good guy. Thanks Dave.

Julie Murchinson: (40:47):

It was a really, really nice service. I would say that.

Burda:

Thanks Dave, and thanks Julie. That is all the time we have for today

If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend about the 4sight [00:02:00] Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.