

**HIT Policy Committee  
Information Exchange Workgroup  
Transcript  
June 14, 2013**

**Presentation**

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thank you. Good afternoon everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the Health IT Policy Committee's Information Exchange Workgroup. Thank you for being patient this morning as we got started. This call is a public call and there is time for public comment on the agenda and the call is also being recorded so please make sure you identify yourself when speaking. I'll now go through the Workgroup roll call. Micky Tripathi?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks, Micky. Peter DeVault? Jeff Donnell? Jonah Frohlich? Larry Garber?

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

Here till just before 10:00.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Okay, thanks, Larry. Dave Goetz? James Golden? David Kendrick? Charles Kennedy? Ted Kremer. Arien Malec? Deven McGraw?

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

Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks, Deven. Stephanie Reel? Cris Ross? Steven Stack? Chris Tashjian? Jon Teichrow? Amy Zimmerman? Tim Cromwell? And Jessica Kahn? And Kory Mertz from ONC?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks, Kory and are there any other ONC staff members on the line?

**Michelle Consolazio Nelson – Office of the National Coordinator**

Hey, MacKenzie, this is Michelle.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Hey, Michelle. Okay with that I'll turn the agenda back over to you Micky.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay, great, thanks MacKenzie and thanks Larry, Chris and Deven for joining I know we have relatively low turnout today, this was an ad hoc scheduled meeting and I apologize I wasn't able to get the materials out earlier, but it's great Deven in particular getting your voice in on this with respect to the work that the Privacy and Security Tiger Team has done in various parts of this I think will be an important contribution to shaping this.

So, why don't we dive into the presentation for Chris and Larry what I did was refined some of the slides that you saw earlier from the last call to take into account some of the comments that we got back and also try to change the format so that it's starting to look like the draft recommendations that we would present. So, it sort of reads a little bit more like a recommendation that we would seek approval from the HIT Policy Committee for and walk through – so if you could go to the next slide, please.

So, walk through a little bit of the work plan which again is, you know, our conveying to the Policy Committee in July what our work plan is and what we're going to cover at that meeting and then what we would anticipate covering in September for the final recommendations and then talk a little more about the query exchange recommendations which is following up from what we did on the last call and then starting to think about provider directory recommendations. So, if we can go to the next slide, please.

So, I'll walk through this quickly. I know Deven you weren't on the last call so slow me down or stop me at any point if there is something you want to weigh in on.

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

Okay.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

But, first thing, you know, we did cover this slide, I did change it a little bit because we got some comments back on this slide, but this was, you know, just sort of a background. We did have three issues that were in the Stage 3 Request for Comment that went out at the end of last year query for patient record, provider directory and data portability and one question that we discussed on the last Workgroup call is are there any market developments or lessons learned that would cause us to amend this list at all and we, you know, talked a little bit about, you know, just some high level perspectives on the market and where it seems to be headed as it relates to these three issues or any others.

Certainly demand for cost vendor query exchange appears to have grown in particular with the rapid growth of ACOs though in some channels query exchange is emerging in the market, in particular Peter DeVault on the last call talked about, you know, how Epic is starting to do that with I think he had said 12 other EHRs in the market so it's not as if it's non-existent, but, you know, I think it's fair to say that such capabilities have generally not kept pace with demand.

And Directed exchange if we look at that as required for Stage 2 is also certainly starting to take shape. The role and function of HISPs is still somewhat murky, however, and the lack of standards for provider directories and security certificates appears to be an obstacle to more rapid progress.

I think just to jump ahead for a second the security certificate issue, meaning digital signatures as well as digital certificates that's an area that is being covered by Dixie Baker's Workgroup over on the HIT Standards Committee already, so it maybe that we really don't have to do anything there so we haven't talked about doing anything more there and arguably that would be something that the Privacy and Security Tiger Team would take on if there was any more work anyway, but just flagging it as an area that right now doesn't have standards.

Industry projections suggest that 25-30 percent of physicians may change EHR systems in the near future, so to the extent that we were looking at data portability for that RFC that strikes me as being, you know, still an important issue if not a more important issue if you start to look at, you know, the amount of churn that could happen in the market in the install base.

And then certainly, you know, I think another point is the demand for patient engagement is growing and there is a lot of entrepreneurial activity in that area in particular and a lot of functionality being developed by the existing EHR vendors as they start to think about patient facing applications. So, that maybe an area that we want to put on the list at least tentatively now as an area that we may want to consider from an IE Workgroup perspective. Let me pause here and see if there anything on the background. The next slide we talk a little bit about all right so how shall we think about what we want to do going forward.

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

I think this all makes good sense.

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

Yeah and it's really helpful to have Micky, it's Deven, I think you guys here on this committee have sort of a lot of on-the-ground experience that informs the work that gets done here that's incredibly helpful.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

**Christopher Tashjian, MD – River Falls Medical Clinics**

This is Chris.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Go ahead Chris.

**Christopher Tashjian, MD – River Falls Medical Clinics**

I just – I met with a number of, what do they call them, HIT fellows earlier in the week and it amazed me that I didn't believe this churn in the marketplace but after that I really believe that there are a lot of people who are going to switch EHRs between Stage 1 and Stage 2, and I think that's going to, again create much bigger – well, I think it will help to be honest with you. I think the ones that can't compete will drop out of EHRs.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, yeah, there seems to be a lot of evidence pointing in that direction both anecdotal like yours as well as some of the industry, you know, sort of surveys that are out there. This morning I got a Wells Fargo Analyst Report suggesting that their crunching of the data suggested that 17 percent of those who attested for – of the EPs who attested for Stage 1 in the first year are so far not attesting in year 2 or they're switching vendors. So, there does seem to be a lot of churn. Next slide, please.

So, in terms of the work plan, you know, it does appear that the original focus areas are still consistent with the aspirational goals of Stage 3 and some of the gaps that still remain from Stages 1 and 2. So, you know, query for a patient record is still I think, you know, by everyone's reckoning, you know, sort of a high priority for Stage 3.

Provider directory to support query as well as Directed exchange, you know, is required for Stage 2 that seems to be a – not only – I mean it's an area that we've discussed earlier and now that we're seeing what's going on in the market I think that, you know, it seems like it's an opportunity to revisit and just say, you know, we thought it was important back then, we still think it's important and not only is it important based on what we're seeing in the market, but also as we'll discuss, you know, it's really important for query, people don't tend to think of it as being important for query but it is.

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

It is.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, absolutely. Data portability, you know, we just talked about that and then finally, you know, patient engagement what's after VDT, we didn't – you know, there's obviously a whole bunch of areas related to patient engagement and not suggesting that the IE Workgroup weigh in, you know, sort of, you know, full bore on all of those issues but just a couple of things to note, one is we do have a call coming up based on the last call where Mary Jo Deering had suggested that all of the Workgroups who were involved in patient engagement just, you know, sit down and have a discussion about whose doing what and then, you know, what's the appropriate division responsibilities, so that's coming up on June 25<sup>th</sup> so I would suggest we tentatively leave it on the list right now until we, you know, sort of do that reconciliation.

But the other thing is we did, perhaps last year, I think I remember we did weigh in with a recommendation that ended up getting adopted, I think others probably recommended as well, but that the VDT requirements for transports should be aligned with what they were requiring for transitions of care and in particular the Direct protocol to the extent that was being recommended in other places we had recommended that that be the standard for the T part of VDT as well and that ended up getting adopted, you know, so we did weigh in earlier, you know, on the patient engagement questions. So to the extent that there are those types of issues we may want to just hold the – or reserve the opportunity to do that again once we – pending, you know, seeing how that sort of fleshes out among the Workgroups.

So, would propose then that we focus on four areas for now, you know, and again patient engagement would be the tentative one. For the July Policy Committee meeting we would, you know, recommend – make some high-level recommendations related to the query for patient record and provider directories and then for the September meeting present final recommendations on all four focus areas. Does that feel like a good plan for now?

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

It will be a fun summer.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah.

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

It does, you're skipping August?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

I'm trying to pace ourselves, so yeah, exactly. And one other thing that Kory had, you know, Kory likes to add things to our agenda, not Kory, he's just – we're not going to kill the messenger here –

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

We'll let Joy do that to us, no that's not true.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

I think it may actually just be completely a part of what we would want to do anyway is that Farzad apparently has made a request for us to do a little bit more investigation of what's going on in the market with respect to how EHRs are handling interoperability themselves. So, you know, we – on the January 29<sup>th</sup> joint Policy Committee/Standards Committee hearing I did a presentation on the current state of HIE where I talked a little bit about what Cerner, Epic, eClinicalWorks and Athena were doing, and I think the thought there was, you know, looking – since then CommonWell has been announced, other vendors are, you know, obviously expanding their capabilities, a lot of HISP activity going on.

And Farzad has asked us to sort of do a little bit of a landscape check on, you know, what's going on in the EHR vendor community and have that inform what we're going to do and then perhaps give a, you know, brief summary of what we're finding there as well on the September presentation.

So, we were talking a little bit on the precall about, you know, maybe doing – we can have an off line reach out to the different EHR vendors and then to the extent that we have a call perhaps in August where we have room in the agenda maybe we could bring in a couple of the vendors to talk a little bit more in greater depth to the Workgroup about what they're doing.

We do already have, you know, Peter DeVault from Epic and Arien from RelayHealth which is, you know, a driver of CommonWell already on the Workgroup. So, we do have some cast of people who can discuss in greater depth what they're doing, but probably want to cast the net more widely I would think. So, why don't we dive in then? Next slide, please.

So, the background on the query for a patient record and we discussed this on the last call a little bit is, you know, we did have the public comments from the RFC as well as comments from the HIT Standards Committee that, you know, were essentially consistent in their feedback that the suggestions that we had put out there be simplified and generalized. They noted that it involved the complex set of back and forth transactions which they thought, you know, would be difficult to implement or to move forward with as a set of standards and also that what we had there implied a very specific set of user work flows that also they were somewhat concerned with.

So, you know, based on that feedback we anticipate developing recommendations that we thought about in two broad chunks in the last call. I didn't break it out specifically like this but we did kind of work through this, so, you know, all of you need to tell me whether you think that this is an appropriate way of dividing up or if there is a better way. But, I've broken it up into two things. One is just sort of general principles to guide standards and the requirements decision and the second is a more focused drill down on what might be the minimum sufficient elements or requirements of a query response set of transactions. So, next slide. We can dive right into it and engage there.

So, in terms of, you know, a set of principles and we talked a little bit about this, it was organized a little bit differently on the last call but I think, you know, I think the content reflects that as well as some of the feedback that we got on the call. So, you know, sort of a draft recommendation would be that, you know, we are essentially recommending that the HIT Policy Committee approve that they are recommending the following guidelines be used for establishing requirements and standards for query-based exchange.

So, a couple of key principles, one, you know, continuity, build on the Stage 1 and Stage 2 approaches and infrastructure for Directed exchange where possible and allow use of organized HIE infrastructures where applicable and available. So, what does that mean? In the last version of this you may recall that I had Direct specified in there where the idea was that we've already got Direct to the extent that we can build on that, you know, that would be a good thing.

Also, with an eye toward we've got HISP infrastructure being deployed like provider directories, like, you know, PKI or other forms of security that to the extent that those are being deployed that, you know, we may want to, you know, have a recommendation that you should build on those things rather than trying to create something, you know, out the whole cloth.

One of the pieces of feedback that we got on the last call was that, well if we're not going to specify IHE for example as a set of protocols that are being used in the market then maybe we shouldn't call out Direct with a capital "D" either and just sort of step back and just, you know, not talk about any particular standard. So, I just did step back and say – and talk about Directed exchange, but, you know, that would be kind of the idea there with respect to continuity.

I'll just keep going, stop me wherever you feel that you've got something you want to say. With respect to simplification setting a goal of having query and response happen in a single or at least minimal set of transactions. On the last call this read single, I think it was Peter DeVault who had suggested, you know, maybe we want to say minimal rather than single so I just put in, you know, minimal, but the idea would be, you know, based on that feedback that there were too many complex back and forth kinds of things that in the previous iteration of this we might want to, you know, sort of set that again as a goal and recommend that they get as far as they can on that.

Generalizations would be about having, you know, a set of standards and requirements that accommodate flexibility and don't over specify as regarding use cases, work flows, install-based capabilities and legal policy considerations. So, what does that mean?

So, just some examples, allowing clinical sources to have the flexibility in how they respond to requests. So, what that means is that you can imagine a scenario where a requesting entity and a requesting system sends a query for information, the clinical source system it turns out that right now in terms of, you know, the market very few systems, if any, have the ability to respond to a granular or targeted or I shouldn't use targeted because that has a different meaning in the Tiger Team context or a specific request for a particular type of information.

So, a query that says send me all the lab results on Lawrence Garber or send me, you know, all the operative notes or send me the last discharge summary for, you know, for Lawrence Garber most systems don't have the ability to respond to that kind of request and also, you know, without further requirements on data segmentation, you know, we probably can't anticipate that they will. So, the idea is to allow some flexibility so that a clinical source can respond with whatever they're able to respond and whatever they think appropriate based on, you know, as we'll discuss authorization, authentication all of that stuff.

So, you know, maybe some organizations would just say "I'm just going to respond to every outside request with a medical summary, you know, that doesn't have sensitive conditions" or whatever that's all I'm going to respond with because that's all I can do, that would be an example of that kind of flexibility.

The other in the next example is remaining flexible to legal and policy variation across states and organizations and we know, you know, we've tangled with this in a variety of different settings. Every state has different rules, different thresholds around this stuff, very hard to have a national standard that can accommodate in a very detailed granular way all that variation that exists out in the market.

So, then finally in terms of a principle, set of principles the idea of perhaps recommending some minimum sufficient requirements for a standard or a set of requirements and I just ticked these off and then the next recommendation goes into detail on those, but the idea would be that whatever it is we do we've got to have authentication of the requesting entity, you've got to have the ability to discover security credentials for encryption, you've got to have a way to validate patient identity, you've got to have a way of assuring patient authorization, you've got to have a way of responding to the requesting entity even if you have nothing, presumably you want to be able to respond back and say I've got nothing or I don't like, you know, I'm not assured by whatever you've represented for authorization or whatever that is, you've got to be able to do that.

And then you have to have some way of logging the transactions and importantly the disclosures, not just the transaction but whose patient information have you sent. So, unlike Direct this, you know, really can't be payload agnostic in that way. So, let me pause here and see if this makes sense?

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

I think it makes great sense. I like how you laid this out.

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

It does Micky, this is – I'm sort of noticing how well it was tracking with the work that we had done in the Tiger Team in the Policy Committee on policies around query and then I peeked ahead at the next slides and it looked even more like that.

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

I see cut and paste.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Not cut and paste but I learned well through those calls.

**Christopher Tashjian, MD – River Falls Medical Clinics**

I like the flexibility. I mean, you need that flexibility if it's going to work.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

Yeah, well absolutely, I mean, you know, it's just – it's not an environment that's going to get standardized, you know, at least with respect to the consent issues any time soon if ever.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay, great, well, next slide, please. So, in diving down into this, you know, I don't know, I have a picture that sort of describes this at the very end in the backup slides, but maybe we can walk through it here and if the picture helps, you know, we can decide whether, you know, that makes sense to, you know, to go through it that way with the Policy Committee, but the second recommendation would be diving down into the sufficient requirements.

So, in a way what I tried to do is break it out into query system and responding system and kind of do it in, you know "kind of order" I'll put that in quotes, obviously these are all bits and bites, so, you know, a lot of things happens simultaneously or virtually simultaneously, but in terms of a logical flow, you know, you've got to have the ability to discover the address and security credentials of the clinical source and this is what we were talking about before that the importance of the provider directory even for query – if I'm going to query another system I've got to be able to find who they are and I need to be able to get their public key if a PKI is the type of security that we're talking about in order to encrypt my query to begin with.

Then I've got to be able to present authenticating credentials of myself. I've got to be able to present the patient identifying information and we'll align this. We can provide more detail on what the Tiger Team, the Privacy and Security Tiger Team recommended here, but certainly a minimum one from what I gathered in the quick review of those recommendations as well as Deven your e-mail was that a standard around demographic information would be an important, you know, sort of baseline for that.

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

Yeah, yeah, I mean, we recommended that more than a year ago.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, right, so maybe this is the opportunity to – and some of that may be included I just – I haven't – I would have to go back and look at what's required in Stage 2 in terms of, you know, sort of content on C-CDA. I just kind of forget where that is with respect to demographic information maybe Larry or Chris knows?

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

I mean, you can put anything in them.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay, yeah that's the concern, okay.

**Christopher Tashjian, MD – River Falls Medical Clinics**

It's wide open.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, yeah, so maybe this is the opportunity to suggest that be a part of this. Presenting authorizing credentials, you know, for a specific patient level of request, in the next slide I tried to give a little bit more context with this so maybe I can just go through this and then in the next slide talk a little bit more about what that might mean.

Indicate the type of information being requested, I put optional here because of what I was talking about before, that, you know, you could have, you know, and maybe anticipating where this is going to head hopefully, you know, a query standard that allows someone to say I'm just looking for the labs recognizing though that the responding entity may not be able to deliver that kind of, you know, sort of request specific to what you're asking.

And then I need to be able to securely transmit the query message, I need to be able to log that transaction and then once it comes back I need to be able to receive the responding information or the reason the request was not fulfilled by the clinical source and then need to be able to log the transaction in the disclosure.

Then with respect to the responding system I need to be able to validate the authenticating credentials of the requesting entity. I need to be able to match the patient, verify the authorization in some way, check for and respond with the requested information and respond either with the requested information or standard information like just a general medical summary or the reason for not fulfilling the request and then finally be able to log the transaction in the disclosure.

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

So, the only thing Micky that is slightly different from what we had said from a policy matter is that we did not expressly require a data holder in response to a query to give a reason for why they might not be providing the records. They have to respond to a query even if the response is “I can’t” or an “I won’t release these records.”

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Right.

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

But we didn’t take the step of saying you have to say why.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Okay.

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

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
My thought here was that it would be just what you said.

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

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
That, you know, I don’t have the record or, you know, authorization not valid or whatever it is.

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

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
But not any more than that.

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

**Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group**  
That’s what I thought you were talking about too Micky.

**Deven McGraw, JD, MPH – Director – Center for Democracy & Technology**  
Okay then if it’s not any more than that then it’s arguably quite consistent.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Okay.

**Christopher Tashjian, MD – River Falls Medical Clinics**

So, I think from a provider’s stand-point it’s important to know that reason.

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

Well, maybe, at the same time, you know, maybe the reason is quite revealing and, you know, at this point, you know, if you – it’s the disclosing entity that is under the legal obligation to disclose – and it’s permissive under HIPAA and so there may be a multitude of reasons and some of them we might not particularly like, but we didn’t think that – that we were going to change that state of play.

**Christopher Tashjian, MD – River Falls Medical Clinics**

I’m just –

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

And it may not – and that's not – while you may as a requesting provider want to know why you're not getting the data it's really the data holder's prerogative about whether they do or they don't tell you.

**Christopher Tashjian, MD – River Falls Medical Clinics**

No, no, no I understand that it's their prerogative, but if they were never seen at that institution then I can go back to the patient and say "are you sure you got the right place?"

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Right.

**Christopher Tashjian, MD – River Falls Medical Clinics**

You know, are you sure you're sending us to the right place because they don't have it.

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

Well, right –

**Christopher Tashjian, MD – River Falls Medical Clinics**

And I think that would be helpful.

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

I strongly suspect that any time it's the case that the record doesn't exist in the institution that that's exactly the response you'll get.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Right, yeah.

**Christopher Tashjian, MD – River Falls Medical Clinics**

So, I just –

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

Is there a need –

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Go ahead Larry.

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

Is there a need to say, you know, or HIPAA appropriate reason request not fulfilled or is that just implied?

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

I frankly don't think this needs to be specified in a standardized way. We didn't think so.

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

Okay.

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

And you have to respond.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Right, right.

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

To a request you can't just leave the door unanswered and that's essentially the policy step that was taken by NWHIN Exchange now called eHealth Exchange.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, so maybe we can specify that, clarify that, that we're basically saying the same thing which is that you have to respond. I can see a minimum response set to Chris's point being just, you know, at least let me know, acknowledge that you got the request and let me know whether you have information on the patient or not.

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

Right.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

And anything beyond that is, you know, call me.

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

Well, but actually, but wait if the two responses are “we don’t have the patient” or “I’m not allowed to tell you whether we have the patient” then obviously the second one is that we had the patient but I can’t tell you. So, I mean, so we have to be thoughtful about what the responses are.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

Yes.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

How about nurney, nurney, nurney? Okay and if we move to the next slide I tried to just flesh out some of these ideas a little bit more to, you know, sort of say, all right so discoverability, you know, want to be able to specify a little bit more, but the standards should, you know, should leverage but perhaps not be restricted to, you know, the considerable HISP infrastructure that’s being deployed to enable discoverability of Direct addresses and security credentials for Directed exchange. Basically, the idea there is don’t remind blind to that. Fair enough that it not be restricted to that.

Authentication, again, you know, basically the same thing that, you know, there is a whole – the HISP infrastructure and everything that Directed exchange is doing and they now have an ONC grant to, you know, help further that, you know, that is working on a federated authentication and scalable authentication kind of approach, you know, maybe that is one way of tackling at least one part of the problem, it doesn’t solve all the problems.

With respect to authorizations, you know, covered this a little bit more but again just wanted to elaborate a little bit more on it that, you know, we’ve got lots of locally determined authorization policies. So, very hard to try to hardwire that into a standard. So, you know, even what we’re seeing even with Direct for example in Massachusetts the Statewide HIE for whatever reason the legislature made it an opt in requirement to send information over the statewide HIE even if it’s just essentially a Direct transaction.

So, you know, that has the implication that we have a unique authorization requirement that it’s a little bit more than what Direct, the applicability statement was anticipating. New Hampshire has, you know, a law that says that the Statewide HIE can only be used for treatment purposes among providers, we got that expanded to allow public health transactions but it still doesn’t allow patients, first and foremost, as well as payers to transact anything over the statewide HIE. So, again now you’ve got another HISP that even in a Direct exchange world has unique authorization requirements and so you need, you know, the flexibility, something that allows you to be flexible to those kinds of things but still have as much standardized as possible.

So, the idea there would be that, you know, perhaps a minimum, you know, requirement could be that EHR systems should at least minimally be able to capture a generic consent indicator and include such an indicator in a query message when querying and consume such indicator when being queried. So, what might be, you know, a reason for that kind of thing is you could have as a part of the local transaction or in your trust community an understanding and indeed a definition of what that consent indicator indicates, but at least you’ve got the ability to have that indicator in the EHR capturable as well as a part of the query message. And that indicator could mean different things in different jurisdictions but that’s what you have to do to accommodate the different authorization requirements that we see in the market.

And then the last bullet just deals with the other side of the transaction that if you get one of those indicators you should, well wait a minute, should have the ability to send and receive, oh, so the last one is just dealing with, you know, do we want to say something about, well, and this is getting a little bit at what – I think what Epic does but also what the SSA experiment in this and I'm forgetting the name of that, that they did with Beth Israel, where they basically passed consent documents.

So, what they do with Beth Israel is that the SSA for disability, this is for disability, the SSA will make a request to Beth Israel Deaconess Medical Center for disability, clinical information related to disability of a particular patient as a matter of their relationship Beth Israel trusts that SSA is getting appropriate consent from all of their patients or, you know, all the patients in order to sign up for disability I think do sign something and that's a representation that's being made, but then what happens is that Beth Israel responds with the clinical information but they also attach a scanned copy of the authorization that they have from the patient.

So, it all happens in a single set of transactions, but they do attach the consent document. So, the thought here was, you know, should we say that the EHR system should have the ability to attach consent documents where that ends up becoming a part of the authorization understanding between those parties.

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

But in that scenario you're saying that the record holder is showing that they've already gotten consent to send this whereas in most or Beth Israel is sending it back to SSA they're sending – I mean, they've already received the consent and they're sending that back, whereas or authorization, whereas, you know, the scenario that is most common is going to be that, you know, I've got the patient in front of me and I'm going to query somebody else.

So, you know, do...I'm not sure that I would – I'm not sure that there is significant added value to me sending the signed authorization and also assert that I've received the appropriate authorization because presumably there will be an automated response and if I assert I got the appropriate authorization they're going to automatically send me back the record in most cases, but if it turns out I didn't get the appropriate one and now I'm sticking in their record an inappropriate authorization, you know, now they're also being responsible for my screw up, and, you know, that means they would have to physically look at every single document that is sent to them to confirm that it, you know, was correct.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, yeah, so I guess my thought on this was that there are lots of different combinations and permutations of how this could work and I think that in the market we see all sorts of variations. You have, you know, relationships like I was just describing where there was a huge amount of out-of-band trust that's already been created so they automate certain things but they essentially send the consent document as a belt and suspenders, you know, sort of audit, you know, kind of backstop rather than it being a triggering event for the release of information, but that's only one way it could happen.

So, the idea here is do we just want to be able to say that an EHR should minimally be able to capture a consent flag and minimally be able to send and receive consent documents if the parties decide through some combination of trust arrangement that they want those things to happen.

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

I think we said that as well Micky. I mean, we assumed when the Tiger Team considered this query issue that there would – that sometimes the consent would be required in order for information to be exchanged as part of a query for treatment purposes, sometimes it wouldn't be required but it might be sent anyway and that at a minimum it would be ideal for the EHR systems to have the ability to communicate any applicable consent or authorization needs or requirements and then be able to record those transactions.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Right.

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

From the request to the consent that might get sent. So, this – we did recommend this and get it adopted by the Policy Committee although maybe not in the exact language but I think the substance is essentially the same.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Micky this is Amy and I joined late, sorry about that, so I'm just picking up the conversation, but when you're talking about this are you talking about just passing sort of a flag that consent was given or are you talking about actually more signed visual documentation or however it's actually obtained from the patient?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

So, the idea here would be that, again, noting that the market has, you know, many, many, many different ways of dealing with this and we see every variant you could imagine, you know, out there that the EHR systems should minimally be able to capture a binary flag that people can use in whatever interpretation they want to make of that binary flag but at least be able to capture a binary flag.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Okay.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

And then secondarily they should be able to send and receive consent documents as well, which would be a scanned copy let's say or, you know, some other way of representing it without, you know, over specifying but just saying that it should be able to do those two things and depending on the trust arrangement that you have you may or may not use either of those or both of those just depending on how you want to do it.

But that at least gives people the ability to know that their EHR has minimal functionality to capture a, you know, a structured field yes/no with respect to consent and to be able to convey the actual consent documentation if that is required for whatever trust arrangement you have.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Okay, thank you that makes it clear and I'm sorry that's because I joined late.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Sure.

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

So, that gets to be quite complicated, in other words, in the interest of simplicity, you know, certainly I think the minimum necessary is the consent flag but it does add a significant level of complexity to say that you're also going to be able to send the signed document.

Now, I agree that, you know, upon request I should – you know, as the holder of records I should always be able to, you know, say, you know, show me that consent that you – authorization that you got from my patient, but I – you know, I'm wondering if you require that to be EHR functionality whether that's going to, you know, make this, you know, make it very difficult for vendors to implement.

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

So, this is Deven, just to be clear the Policy Committee has already adopted recommendations that there ought to be a technical way to communicate both the need for consent or authorization where it exists and to be able to communicate that consent and so that – sort of those technical issues which are typically the province of the Standards Committee have already been tossed over the transom.

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

Okay.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, I think it's a fair point, Larry, I guess I'm just not – because the idea here is just that, you know, that in your query message you should be able to have a system that is able to capture a consent flag and if I want attach a consent document and again it's on the functionality side so it's not saying that the user has to do that it's just saying the EHR capability and I don't know that that's any different – for example Direct allows you to have attachments and then wrap the whole thing up. So, I guess I'm just not sure how technically difficult that is.

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

Okay, just that it will be an image that's all.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

It's a larger file.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, yeah, right.

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

And it's a little trickier how to stick it in the CDA but, you know, it can be done.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

So, the other question is, is this – how about the ability to identify what the exact actual authorizations requirements are for the record holder. And Deven I just want to confirm with you that it's the record holder's local or state policy that must be followed right?

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

Yes.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

Yes.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

And federal, right?

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

Well, right, which would be the case for substance abuse treatment records that are covered by part 2 or records that might be covered by FERPA the Federal Education Rules.

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

All right, so then the question is whether, you know, there ought to be, you know, when you're talking about what the minimum necessary thing it, I mean, part of the minimum necessary to make this work is for that requester needs to be able to figure out what in the world the local requirements are, you know, and these queries could easily be going across states, across the country and so it almost feels like if we're going to be specifying minimum necessary we ought to be specifying that there is some central place where each state records, you know, what their policies are or for release, because otherwise this can't really – I mean it can only work in a community.

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

No, well, I don't think so, actually, I disagree. I mean, while it might be ideal for everyone to understand every state's laws on consent the requester can make the request, they may get the hand we can't – you know, it's really the data holder that's responsible for knowing their own laws, which frankly is enough of a challenge in some states.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**  
Right.

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

What the requester – I mean, sure would it be ideal if they knew ahead of time that they needed to get consent before they could grab this record, absolutely, is that necessarily in order to make this work, frankly I don't think so.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, I mean, I think even like in Massachusetts and New Hampshire, you know, Larry I think we are, you know, working on a statewide approach which would basically give the meaning to what that consent indicator is, it's just a generic flag from the EHR perspective, but, you know, through policy and participation agreements we're, you know, sort of saying "here's what that consent indicator is going to mean."

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

Right within a state that makes sense.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

But the question is in order to facilitate, you know, intrastate communication that's the piece where I think we can't use this until you make it easy enough to figure out what the other states requirement are.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right that maybe right or down the road there is policy alignment so that, you know, Massachusetts and New Hampshire agree that, at some level, that the same rules apply or something, but I don't know that we can solve all of that and still preserve the principle of, you know, not trying to over specify in areas where there is so much variation both now as well as, you know, in what could happen in the future that we run a lot of risks trying to do that I think.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Just so you know, this is Amy, there was, way back going under the HISPC days, there were some early recommendations but no real practical way to implement, is that Larry that was talking about having some sort of centralized sense of what you need for each state?

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

Exactly, I remember the HISPC, yeah.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Yeah and – because I was on that HISPC group or whatever and we never really got very far down the road of how you could do that maintain and operate it, keep it technically like, you know, you'd have to have your system make a call out to see whether what you're requesting is valid or not for that particular state for that. And the other thing we learned is that while what's legal is legal policy in different institutions go often well beyond the legality, right?

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

Yeah.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

So a lot of institutions still want the consent before they'll release information even though they may legally be able to do it, they have their own policies. So, you know, it was very complicated to think about doing some sort of a technical framework on that, I'm sort of with Deven on this one that I think the responsibility is on the releaser to make sure that they know their own laws and rules by which they have to abide.

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

So, from my – you know, as I think of how – as an organization in Massachusetts I would set this up for my EHR I think what I would do is I would look to see if the requester is outside of Massachusetts and I'd automatically say, you know, put the hand up and say "sorry we can't do it" and that, you know, or maybe New York might – New York and California may be high enough that I could release to them, you know, or maybe if New Hampshire we come to an agreement then I could do it in New Hampshire but then everybody else I'd have to automatically just say no.

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

Why?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Why, because aren't you – Deven, correct me if I'm wrong, but aren't you covered by the state law for which you practice on releasing and not by the state law for which the requester is operating in?

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

Absolutely.

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

Exactly, but that's why –

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

So, there is no reason for a blanket policy that you would bar a request from another state. You only have to follow your own state laws. So, if your state allows you to disclose for treatment purposes there's no reason why just because that request comes in from another state you would say no.

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

Okay, I guess I wasn't clear. So, if I don't already have an authorization from the patient to release this electronically to wherever they want and I get a request from Indiana saying that they apparently have received authorization from a patient I'm going to have to – I can't do an automated release to them because I'm going to need to manually figure out what it was that they actually signed.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, I would just say, yeah, for the time being, yes.

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

Well, if you need an authorization in order to release that record, right? Again, I don't know what the law – I actually didn't do privacy work when I practiced law in Massachusetts so I don't know what the Massachusetts privacy laws are, but if there aren't any privacy laws absent you imposing your own personal privacy policy that you will not release any data absent consent that, you know, there isn't any legal reason for you to keep that close of a hold on that data.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

Well, Massachusetts is really ugly in terms of the consent.

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

Okay.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

But, yeah, but I could see –

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

Those are the only laws you have to worry about, you don't have to worry about whether Indiana was doing this properly.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

Well, I am worrying about whether Indiana obtained the consent that – because I have to have a separate consent for mental health, substance abuse, a separate consent for HIV and so our practice is that we need to make sure that the patient is signing for all, you know, for general, for mental health, substance abuse and for HIV independently, you know, all at the same time and I can't expect that someone in Indiana would have known to have done that without actually stopping and looking at what they had signed.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

But, Larry, I think that happens today and that's where I would anticipate that as we start to incrementally allow these kinds of automated query capabilities we would see those sort of mimic, you know, the way we have it today and what I mean by that is, you know, right now Atrius and Beth Israel have an agreement where they deep trust in each other so you allow automated queries and indeed views into each other's EHRs, but if a solo practitioner from Greenfield, you know, made a request of you you're going to say "ah, I need to have a person in the loop" right you've done that through the way you've deployed technology, you don't have an automated way for them to get into your system, why, because you don't know who they are.

So, I would expect that in this context even though we might like to have automated query and response I could image a world where, you know, you had said that anyone outside of the state I may say "no" I would go further to say there may be a lot of organizations that you almost just maintain a white list, you almost say I'm going to have an automated response for this set of organizations as we roll this out and allow them to get an automated response. For the others my automated response might be, you know, call us we need a person in the loop.

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

Agreed and so, I mean, that's exactly where I started from on this is that, you know, I'm going to be doing some settings based on, you know, what I'm going to automatically do and what I'm not.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

And, you know, you're right and the vast majority of healthcare is local, so the vast majority of time this will certainly move us forward. So, I'm okay with that, that's fine.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

All right. So, I know you have to leave Larry. Let me just cover the last two things here just to get your input before you have to jump off. So, in terms of, you know, patient matching I think we actually talked about this on the previous slide, you know, patient identifying information and corresponding matching functions based on standardized demographic fields which is following right from the Privacy and Security Tiger Team recommendations as well. And then the idea that, you know, the data holding entity should determine and indeed has to determine the threshold of assurance needed to establish a match, they're the ones who are responsible at the end of the day.

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

Yes.

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

Yes.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Yes.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Let's see and then finally a response to request, we talked about this, you know, without corresponding data segmentation requirements and for any of you who have followed that, that is really an ugly conversation and I don't think it's moving very far. EHR systems are just not uniformly capable of responding to granular requests for specific types of information.

So, you know, the minimum standard response perhaps, and maybe that something that we want to recommend, that everyone at least have a minimum of standard response which is a lifetime medical summary aligned with the C-CDA content requirements or I put, you know, redacted Blue Button response, redacted meaning, you know, Blue Button responses go back to patients so it includes everything, well I'm probably not going to want to have sensitive conditions and follow that in an automated response. So, there would be some thought needed to be given there.

And then finally, you know, that data holders again are the ones who are going to have to assure that the information in the response is covered by the authorization that has been presented by the requesting entity, so to your point Larry if I don't see an authorization for HIV and I need that then I'm not going to respond with anything that contains HIV.

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

Yeah, I'm not sure if you want that minimum standard response there, you know –

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay.

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

I just – I think that might be too prescriptive.

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

Yeah, I would agree with Larry on that one and it actually is territory that we covered in our recommendations, you know, again it's you have to answer the door.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

But whether you in response provide whatever has been requested, if something specific has been requested or you say, you know, records not here or records not available, or cannot respond to request we've left that flexible.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay. Okay, I'll take that one out then. Okay, unless there are any other thoughts on this, I know we kind of covered the same thing in two slides but this has been a great conversation and is very helpful in refining it.

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

– sorry go ahead?

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

I was just going to say, this is Larry, sorry, first of all I have to leave, but second of all I think this is great, I think it's really going to move the country forward, this is important stuff and you did nice work.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

All right, thanks, Larry.

**Christopher Tashjian, MD – River Falls Medical Clinics**

Yeah, this is Chris and I would echo that, unfortunately I have to leave as well.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay.

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

Very good work. Okay, so we are actually doing – the Tiger Team is doing a virtual hearing on June 24<sup>th</sup> from 1:00 to 4:00 Eastern on what we're calling non-targeted query, which is very by the patient demographics as opposed to when you know who the provider is and you're knocking on a specific provider's door.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

And so if anyone wants to listen in on that you are welcome to.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Great and yeah I hope to be able to make that.

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

Good.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

When was that Deven? That was June 24<sup>th</sup>?

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

The 24<sup>th</sup> from 1:00 to 4:00. I actually think the Rhode Island folks are being invited Amy.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Okay.

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

Stay tuned.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay, next slide. So, this is just one slide on provider directories and we can do more, you know, off line on this but just wanted to introduce, you know, again this is an area that we have spent a lot of time in the past in recommendations and, you know, certainly – and got the feedback back that it was, you know, somewhat over specified, so, you know, trying to back up and also look at where the market is with an eye, you know, with sort of an idea of minimum necessary kinds of recommendations.

So, the background is, you know, provider directories are a critical component of both Direct and query as we know and the current lack of standards, you know, seems to be an obstacle to faster progress in Stage 2 Directed exchange and unless remedies may even impeded Stage 3 query exchange as well. With that in mind two bullets, one is EHR systems have the ability to query external provider directories to discover and consume addressing and security credential information to support Directed and query exchange.

And then the second would be the other side of that, that an EHR system should have the ability to expose a provider directory containing addressing and security credential information to queries from external systems to support Direct and query exchange.

So, there's obviously a lot more specificity that one could, you know, go down that path, but I think that at a minimum, you know, try to get at something that just says, you know, continues, you know, what the applicability statement requires and to the extent that that's already a requirement that's out there but doesn't have anything related to what a provider directory is supposed to have, you know, is this the minimum necessary that we would want to put on that?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

So, Micky, this is Amy, could you talk a little bit more about the second one, so every EHR you're envisioning would have their own – I mean, obviously they're going to keep information in the EHR about providers and who they're communicating with and Direct addresses and stuff, but are you saying that they would then – any other EHR could go hit – like my EHR could hit your EHR and pull out your provider directory? Like, I'm losing the thought here, the use cases.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, so the idea would be that every EHR ought to have an ability for another organization to be able to get addressing information and security credential information for the purpose of addressing and encryption. Now, in the market, you know, you could imagine that happens in a wide variety of ways. So, one would be that, you know, the EHR vendor themselves become a HISP.

So, let's take eClinicalWorks for example, they're developing a HISP as a part of being a HISP they do have a provider directory that, you know, covers their HISP functions and this would essentially just be that final push to say "oh, by the way there are some standards around that and you do need to expose that." And being a HISP they want to do that but everyone is struggling a little bit with how that works.

You could imagine another EHR vendor perhaps they're not a HISP and then what they would do is either partner with a HISP who – because they do have to enable Direct exchange in some way, shape or form. So, in those cases, you know, like a MEDITECH for example who don't want to be a HISP and what they're doing in Massachusetts is they're aligning with the Statewide HISP. So, you know, you in this – in the idea of modular certification, you know, I as a hospital let's say if I'm using MEDITECH and I want to be able to represent that I'm using certified technology I would certify with MEDITECH and the Massachusetts Statewide HISP together as being my, you know, my attesting required software.

So, it allows the flexibility in the market. It doesn't mean that literally every EHR vendor has to do this, but they would need to have an ability to enable Directed exchange to make their provider directory part of an overall, you know, sort of ecosystem and allows the user to decide how they want to deploy that as well.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Yeah, so I guess the part that I'm struggling with is maybe just the concept of provider directory in a more narrow sense here and part of that is just where I personally am coming from because in Rhode Island we're thinking of actually creating an authoritative statewide provider directory that a whole bunch of state and other systems could, you know, make a web services call to where we'd have one, at least authoritative, well maintained, high quality level, you know, if we can ever pull this off, provider directory and so I'm just trying to think about semantically how this differs from the concept that I'm thinking of there so that it's not getting confusing, because I don't know if other states are going down this road as well.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

No, so this could be consistent with that to the extent that this would give – what this would do is it would say to an EHR vendor you need to have some way of exposing your provider directory to outside queries for minimal, you know, kinds of transactions, basically to receive a Directed message or to receive a query and so how they choose to deploy that in your case this could be, you know, something that the state could leverage for example because the EHR vendor is minimally required to expose that so if nothing else maybe that is how they integrate their provider directory with you statewide one should they choose to. Again, that, as you know, is a conversation between you and every one of those EHR vendors.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Right.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right now you don't have any standards for what provider directory integration would be. So, you know, that would be the opportunity to be able to say – to know that a vendor at least has these minimal capabilities that you could leverage, you know, whether the – and then it would be the provider directories – the EHR vendors, you know, sort of ability to decide whether they want to participate in your thing and allow that to be something that they want their customers to leverage or they just expose it themselves or they do both.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Okay, yeah, because I wasn't thinking – I mean, we haven't been talking about it or thinking about it from the specific EHR/provider office level we've been thinking about, you know, just needing it for bigger statewide and other systems and who knows if it would get into credentialing or not it's a bigger, longer discussion, but I don't want to derail this conversation I'm just trying to understand how you're using the term because I think of it in the context in which I've been working on it for us in the state here.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, right.

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

I do think Micky that it would be helpful for you to scope out those examples.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay.

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

With the recommendation.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

And I think that the road is a little better paved for this recommendation at this particular time because we did just get finished with the set of policy recommendations on query that presumes that you're going to know who – at least one of the patient's previous providers and you're going to be knocking on a specific door. How do you find that door?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes, yes, right, exactly, yes, okay, great. Yeah, I agree with you I think the road is sort of paved now that people are seeing in the market the –

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

I never understood why this thing got hung up in the first place, but the more simplified version of this with some examples, and again giving timing, which can frequently be everything –

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

It maybe the lucky July.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right, okay, okay, well I will flesh this out then with some examples and I think that's a great idea and, you know, Amy those are great questions and helps, you know, sort of force the thinking about okay how would this actually work in the market and how do we represent, you know, this as being sort of minimal sufficient but still allowing flexibility.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Hey, Micky, one question on this?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

So, you know, with the query response piece before you were kind of inserting the ability for a provider to use an HIE or RHIO or whatever, you know, an existing service provider like that, do you think there needs to be some thinking around that same level with how this would work with the provider directory, you know, if I was a provider relying on my local HIO or something, would there need to be some variability in this requirement for them? I don't know just a thought.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Let me just think about that for a second. You know, I don't – I guess my initial thought is that the way this stuff seems to have been done, you know, in Stage 1 and Stage 2 with the idea of modular certification capability is that, you know, you essentially say that, you know, whatever is represented as a complete system has to have all of these parts and so if you have an EHR that has this capability and is certified that means that you could just use that, you know, as a standalone to meet your requirement – to at least meet the requirement that you are using certified technology whether there is a use component to that that says you need to use a provider directory, you know, we're not talking about that here this is just about the certification.

If the HIE organization separately and on its own gets certified for this provider directory functionality then there are two options, I think one is that you've got a complete EHR but you use the HIE so you want to attest with them anyway if they're certified, you don't have to, but you could. The second would be that your EHR is not a complete EHR meaning the vendor that has your documentation, you know, system is not a complete EHR and doesn't have this provider directory capability and then you would use the statewide HIE or that regional HIE whatever it is if they're certified and attest with both to be your complete EHR.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Yeah.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Does that make sense?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Yeah, no, I, you know, I just want to make sure if there is some specific thinking that needs to go in to make sure the way this gets crafted doesn't cause a challenge to being able to do that I guess is what I – you know, I would just throw that out there as something that –

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes, right.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Might not be an issue at all, but, you know, sometimes with these things you end up with unintended consequences.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, oh, yeah, absolutely. So, maybe we can flesh that out in the example too.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Yeah.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

And, you know, it does go back to that principle that was early on that sort of said, you know, like we've done in Stage 1 and Stage 2 you should allow the use of organized HIE functions to the extent that those exist.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Yeah.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

As, you know, sort of surrogates in a way so that would be consistent with that as well.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Okay.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay, why don't we move to the next slide which is just the next steps I think? So, on the – you know, we have one – we have two more calls scheduled there is one on the 28<sup>th</sup> as well, but, you know, I think that what I would recommend is that, you know, so on the next call we discuss finalization of the query exchange and provider directory, you know, thoughts here, we'll kind of flesh that out, try to get it out a little bit more in advance so that people have a chance to look at it.

And then also, hopefully that won't take that long because we've had a couple of calls on the query exchange and, you know, provider directory may take a little bit more work but if we can get to the data portability, you know, on that call that might mean that we can do everything off line between then and the July 9<sup>th</sup> Policy Committee, otherwise we do have a call on the books for the 28<sup>th</sup> that we can reserve the right to use if we need it, but we may be able to accomplish the rest offline.

There are two weeks actually from the 21<sup>st</sup>, there is the following week we do have a call and then the following week is the week of July 4<sup>th</sup> so we didn't schedule a call that week for obvious reasons, but there are two weeks that we would have to do work off line in the run up to the July 9<sup>th</sup> meeting.

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

This sounds great Micky, would it be helpful if I sent you a copy of the – or the link to the transmittal letter for those query recommendations?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yeah, that would be great.

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

Okay, will do.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay. Okay, great and why don't I – since we have just a couple more minutes let me just – if we can jump ahead two slides I don't know if the background is in here. Yeah, so, I did, you know, put this into a schematic that we, you know, kind of looked at a high-level at the last meeting. I can just keep it as backup, but, you know, this could be another way that helps people, you know, sort of visually kind of see a little bit of what we're talking about as, you know, kind of a minimal set. You run the danger of it being seen as over specifying, so –

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

Well, but also again, you know, so keep in mind that the policy and maybe when you actually see the transmittal letter you'll see more of the scope of what already got done, right?

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes.

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

So, one thing I think we need to be careful of is not suggesting that we're re-opening that discussion.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Right.

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

But instead building on it.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes, yes.

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

But I think you can decide after you've seen that whether this sort of looks like it's over specifying because it doesn't to me.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay.

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

But that's because I sort of feel like that groundwork has already been laid but you just never know.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Yes, yes, right you do never know, yes, yes, but, you know, yeah, so why don't I take a look at that and I mean if we feel that the pros version that we just went through is clear and is a good way to present to the Policy Committee than that's totally fine. Okay, great, well thanks everyone for your engagement and for the great discussion and thoughts. So, I'll get that stuff from Deven we'll turn this around again with some of the refinements that we just talked about and we'll anticipate the call on the 21<sup>st</sup>.

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

Sounds great.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

MacKenzie?

**Public Comment**

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Sure, operator can you please open the lines for public comment?

**Caitlin Collins – 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 do not have any comment at this time.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Okay, great, thank you everyone.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks everybody have a good weekend.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Executive Office of Health & Human Services**

Bye-bye.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator**

Thanks.

**Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative**

Bye, you too.