

**HIT Policy Committee
Information Exchange Workgroup
Transcript
July 29, 2013**

Presentation

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

Thank you. Good afternoon, everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Information Exchange Worker. This is a public meeting and there will be time for public comments. Please remember to speak your name when speaking for the transcript, and I will now go through the roll. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative

Here.

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

Amy Zimmerman? Arien Malec? Charles Kennedy? Chris Tashjian?

Christopher Tashjian – River Falls Medical Clinics

Here.

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

Technology

Chris Ross? Dave Goetz?

Dave Goetz – OptumInsight

Here.

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

Deven McGraw? James Golden? Jeff Donnell? John Teichrow? Jonah Frohlich? Peter DeVault? Larry Garber?

Larry Garber – Reliant Medical Group

Here.

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

Stephanie Reel? Steven Stack? Ted Kremer?

Ted Kremer – Cal eConnect – CEO

Here.

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

Technology

David Kendrick? Jessica Kahn? Tim Cromwell? Are there any ONC staff members on the line?

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

This is Kory Mertz.

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

Hi, Kory. With that, I will pass it over to Micky.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, great. Thanks, Michelle. Thanks everyone from the work group who joined today. This is the Information Exchange Work Group of the HIT Policy Committee. We're going to continue our build up to the August 7 meeting, at which we will finalize our recommendations to the Policy Committee related to Stage 3 Meaningful Use recommendations, whether they're Meaningful Use certification for—and I guess that's the last meeting that we'll be presenting at, if I'm not mistaken, for the recommendation.

We did have a very good presentation to the Policy Committee last time, as we discussed at the last work group meeting. I think that most of the people on this call, perhaps with the exception of Larry, were not on the last call. Is that correct? Well, anyway, I think that—so that's great, because we, that means we're sort of getting the input from a broader array of work group members in a more asynchronous mode.

We will review—so just to give everyone, since you weren't on the call last time, we did get a very good reception at the Policy Committee on our recommendations related to query as well as provider directory and the Policy Committee approved all of them, but asked us to come back and just reconsider or have further discussion related to the authentication requirements that we had in there with respect to provider directory transactions. We'll first hit that in the first part of the agenda here, and then we're going to move to data portability.

On the last call, we did discuss the provider directory—we discussed both of these things and we did come out with where I think was sort of a consensus view among the people who were there on an approach for authentication, the authentication question. What we're going to do is just go over where I think we landed on that and make sure all of you are comfortable with it, and then we'll dive into the data portability conversation.

Let me pause here and see if anyone has any questions or comments before we dive in. Okay, so let's see. I'm not in—here I am. Yeah, if we can—for the slides, please; next slide; and next slide.

Just to give background to those on the call who weren't at the last meeting, you may recall from the provider directory recommendations that we sort of had a structure that just talked about what the elements of a provider directory transaction might entail. The idea was—and we had various components of that. One was to be able to query a provider directory across entities; the other was to expose a provider directory; and then there was a third category which was to be able to populate an external provider directory, as it were, to be able to send information to keep another provider directory updated.

While it wasn't the main thrust of our discussions as we're building that recommendation, we did put in there a single line in each one that made reference to authentication being a part of the transaction, where the idea would be that whatever you're doing in an electronic transaction, you're going to want to have some sense of who's asking. There was some concern expressed at the Policy Committee; namely, from Doug Fridsma on the standards side and Farzad also picked up a little bit on this, which was just a general concern about how fully baked that ought to be in the recommendation with respect to a standard.

I think that was, there was a little bit of concern, I think, that that might be somewhat at odds with where the S&I framework had been headed, with the idea being that that provider—where, in that work, as you may know, there's sort of a DNS approach and an LDAP approach. The idea sort of had an implicit if not explicit assumption about provider directories being open so that you could have as wide exposure as possible for organizations and providers who want to be able to discover other providers and send to them.

I think in our provider directory conversations, and this came through last week as well, we did note, and it seemed to be something that almost everyone had sort of seen in the market, that we are seeing that provider directories are, in general, not being fully exposed without being embedded in some kind of trust fabric. As we think about our certification recommendation here, which was focused specifically on provider directory recommendations within the context of high tech certification, you could imagine that provider directories, at least at the get go, most of them are going to be resident in electronic health record systems. It's hard to imagine that not being within some type of authentic or trust framework.

The general issue seemed to remain that we did sort of have a group sense that authentication seems to be an important part of what we're seeing in the market, but we also, I think—and this is me in particular, I think I was remiss in not making clear to the Policy Committee that our recommendation was really focused on the certification requirement and not on a Meaningful Use behavioral requirement. In particular, what that meant was that we're not saying that every single transaction would have to have an authentication component to it. Indeed, if people wanted to implement it without that, that ought to be their prerogative to do so.

What we were saying was that this ought to be a certification requirement so that everyone could be assured that they have the technology to be able to enable that type of authentication within a trust fabric if they wanted to. I think if I had made that clearer in the Policy Committee meeting, I suspect that this wouldn't really be an issue now, but be that as it may, we do want to make sure that we have a full consideration of the question. I will make sure to make that clear on August 7th, and it may be that it might just be fine, but we did—

Christopher Tashjian – River Falls Medical Clinics

But it was actually, but it was a good thing that we actually had an opportunity to take a second look at it because of the lines you added in red on your next slide, which we would've missed otherwise.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, *[Laughter]* so why don't we move to the next slide? The surprising element of the conversation was that we ended up, as it were, doubling down on the authentication *[Laughter]* language, because we did have some commentary from—and I'm completely spacing on his name; who was it?

Christopher Tashjian – River Falls Medical Clinics

John Feikema.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, who was a part of the S&I framework team, and he noted that while the S&I framework work is not requiring, did not have anything in it related to a requester presenting authenticating credentials to the provider directory holder, they actually do have something in there that refers to the provider director holder being able to present authenticating credentials to the requester, so the requester would have some assurance of the validity of the provider directory. *[Laughter]* That we didn't have, so we ended up, ironically, actually putting in that as a recommendation for certification, so in effect having some type of authentication capability on both ends.

That's what you see in red on the slide here, and I think it was the consensus view of those who were on the call last time that if we make clear to the Policy Committee that this is a certification requirement but that maximum flexibility and an opportunity in the market would sort of suggest that we ought to include these as certification requirements so that those who choose to have this type of authentication for their provider directories ought to be assured that they have the technology that can do it, but certainly doesn't say anything about requiring that they do that if they don't feel the need to do it.

So that was a very long build up, I apologize, but I wanted to make sure everyone understood the background. Let me open it up and see if—Larry, you were on the call last time, or if anyone else, certainly any of you who weren't on the call last time, if you have any questions or comments or anything additional we ought to be thinking about here.

Larry Garber – Reliant Medical Group

I would think that it's so important—this is Larry—it's so important, the red pieces that you have in there, because that would've been a hole in our security where basically you could put in some fake address or someone could spoof being the provider directory and put some other address, and then we would accidentally release information to somebody else at this fake address.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Larry Garber – Reliant Medical Group

It was actually, it was a great pick up.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. I had a whole business plan written on spoofing provider directories and now it's gone. *[Laughter]*
I got caught.

Larry Garber – Reliant Medical Group

Partners in Russia, you know.

Micky Tripathi – Massachusetts eHealth Collaborative

Exactly. *[Laughter]* It was all lined up. *[Laughter]* No, I agree. I think it's a great touch. Dave, Chris, Ted? Ted, you're—I mean, I know in Rochester, I don't know what exactly your architecture is for your provider directory, but does this, do the issues that we're reflecting here seem important, and would this be something that you would see as being enabling of your efforts in other things that you're seeing in the market?

Ted Kremer – Cal eConnect – CEO

No, it makes sense, and I think the additions make sense, too.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Ted Kremer – Cal eConnect – CEO

And—I'm sorry, go ahead.

Christopher Tashjian – River Falls Medical Clinics

No, no, this is just Chris Tashjian; I'm just saying, "Ditto; this all makes sense."

Ted Kremer – Cal eConnect – CEO

I assume that yearly, what this amounts to is, once you've done this, it then becomes just part of an ongoing set of transactions that you are—will this occur at every instance of a query back and forth, these four steps?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I mean, that would essentially be the idea. Yep.

Ted Kremer – Cal eConnect – CEO

Okay, got it—but again, automated fashion; not anything that makes the provider sitting out there looking for a directory address to sit and spin in circles.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. What we did is, we put in as a principle that this ought to happen in a single set of transactions—a query and a response. Again, whether it's actually a single set of transactions is what will be determined by the market and by standards and all that, but we set that as a goal from a policy perspective.

Ted Kremer – Cal eConnect – CEO

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, great. Well, unless there are any further comments here, we'll go with this, and why don't we move to data portability?

What I did was, I took our discussion from last time and tried to put it in the same framework that we have had for the query and the provider directory recommendations. That namely provides some background, just to give the Policy Committee a bit of context, and then as crisply stated a recommendation as possible, and then some principles behind that which provide some context for the recommendations. One, I'll walk through those, chime in at any time. This language is actually new to everyone, so feel free to chime in wherever and we can make edits according to whatever you feel is appropriate.

Next slide, please. So, in terms of background, and we've talked about some of these things, but just, again, to set the context, the EHR install base—oops, I can already see a typo—as the EHR install base grows, we expect to see growing demand for data portability or cost under systems. I mean, there's certainly market surveys suggesting that there could be a lot of term and near term at 20 to 30 percent of providers switching vendors perhaps in the next two years, would suggest that perhaps there's some urgency to the issue. In general, it's certainly just a mathematical function; as your install base grows, you're just going to statistically start to see more and more turn as vendors come and go, as people change their minds, you know, what have you. Data portability will become a bigger issue over time.

Certainly the fact that there is already such turn or perhaps such anticipated turn is a little bit of a testament to the urgency of the need, because currently the difficulty of data migration is a pretty large barrier to exit for providers contemplating switching vendors. What we've seen in the market is that it's largely an ad hoc process that's highly variable and fraught with potential for errors and lack of continuity in medical record completeness. Also it seems to be difficult to include in contracts in a way that's operationally executable when needed. That's at least what we've seen in the market.

It can be difficult or impossible to execute if the vendor is not cooperative, obviously, and obviously the incentives are not always fully aligned there for the vendor whose being the system migrated from, or the system has been highly customized. The minute you start talking about customized data or customized codes in there or what have you, you start to limit the ability of having a clean migration. Or, finally, if there's a mismatch between the source and the receiving system capabilities, then obviously the migration is going to be driven rapidly to the lowest common denominator at that point, which just makes for a difficult situation.

Let me pause here and see if that resonates with all of you; if there's any tweaking you would do, or anything to add. Okay. Why don't we go ahead.

Larry Garber – Reliant Medical Group

I'm sorry; I was talking into my mute button. This is Larry. The only other thing is, I'm wondering if we should bring into the perspective of patients, when patients move, we need to talk about the transfer of care summary and whatnot, that we're coming up with a new standard for that.

The fact is, when a patient moves from one primary care physician to another primary care physician, I think they'd want more than just their summaries sent and would love to have the benefit of having summaries of all their encounters and all of their test results so they can basically pick up where they left off with their primary care physician, and this would enable that as well. I don't know if we want to bring that angle in here.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. I think that might come up on the next slide, but let's see if it doesn't. If it doesn't, then let's see if we have something. Is there anything else on this slide, then let's see if we can get to Larry's point on the next slide? Okay, why don't we move ahead?

Now, I don't state it quite as cleanly and as patient centric a way as you did, Larry, so maybe we should figure out where to do that. The points here were now about, in these migrations, data or information can be lost, rendered operationally inaccessible, stripped of context or meaning, or misplaced, leading to erroneous context or meaning. Just by coincidence, I was on Facebook the other day, as I do once in a great while, and someone who I went to college with, who's not involved in medicine at all, just put on her newsfeed that she went to her provider who had been announcing for a number of months now that they were switching EHR systems and, "Pardon the construction, blah blah blah," all the signs up there that say, "Pardon the inconvenience." She had the first encounter with her provider on the new system and pulled up her record and her name was right, her demographics were right, but all the clinical information was wrong. It was not her.

Anyway, and she had just randomly posted that; she is not even involved in medicine, but just posted as a patient. There's a lot of stuff out—and obviously, that's a huge safety issue; that goes without saying. Records attached to the wrong patient, data placed in wrong fields. It certainly impacts clinical quality measures and CDS to the extent that links are broken to historical data, links are broken to codify data, whether it's look-back periods, exclusions, whatever, it can cause that—and then administrative to the extent that there's data important to revenue cycle, which can also cause disruption.

I don't think—I thought I had added something, I had something in here about continuity of care management, which I think is getting more at what you're talking about, Larry, but you sort of had it more from the patient side about that being a patient expectation, that systems change and they expect continuity, so maybe we should add that.

Larry Garber – Reliant Medical Group

Well, it's also—I mean, it's also if a patient moves from one place to another. In other words, not even with the patient staying with the same PCP, but what if they move to another PCP, they're, in the ideal world, everything that had been there, every x-ray result and lab result and whatnot that had been in the old system would magically appear in the no one. This same data portability, that's going to help physicians change their systems would actually also help patients when, if they could be made so simple that they could use this to carry their records to their next provider.

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, that's a great point. I don't think we even touched on that last time, which is just sort of, we've been—this is all within the context of sort of provider centric portability, but you're talking about the patient centric portability, right.

Larry Garber – Reliant Medical Group

Yeah.

Micky Tripathi – Massachusetts eHealth Collaborative

So I just want to say, "Send all my records to this new PCP" and the provider wants to just be able to take that slice and send it. Yep.

Larry Garber – Reliant Medical Group

Exactly.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, yeah. That's a good one.

Larry Garber – Reliant Medical Group

It's basically the same functionality.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep, yep, yep. Once again, Larry, completely [*Laughter*] shifting the world view here. All right, so I think that's a great point, so I'll figure out how to weave that in. I like the idea of framing, you know, there's provider centric need for it, and there's a patient centric need for it, and they're basically just different cuts of the same thing.

Larry Garber – Reliant Medical Group

The other thing, also in the background here, you probably want to include the fact that there is medicolegal purposes for retention of records. Do you have that?

Micky Tripathi – Massachusetts eHealth Collaborative

I think, it might be in the Principles and—I'll make a note and we'll see if it's covered in the Principles, but I can put that in the background, too. Yeah, I think I just have, "For medical record continuity," but that isn't really getting at the actual medicolegal issue. I think I do—yeah, in the Principles, I remember, we'll come to it, but in the Principles, what I do say is that "The scope of it should encompass what are and aligned with the legal requirements for medical record purposes" or something like that.

Larry Garber – Reliant Medical Group

So it covers legal medical record retention, so it's actually, there are two pieces of it. One is the retention of medical records, the other is retention of audit trails.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep, yep, and we did talk about that last time and I forgot to add it. Yep. Audit trails. Great. Okay.

The last point on the background is that the standard for data portability would set a common baseline for continuity that'll be vital as the EHR user base grows and matures and as the industry becomes increasingly reliant on electronic medical records and MU related EHR functions. Just noting that it is kind of difficult, I think, as we discovered on our last call to sort of completely define the data migration requirements, because needs may vary locally. However, setting a floor will inspire a greater market dynamism by lowering barriers to exit and promote safety and continuity of care by reducing opportunities for errors. Unless anyone disagrees with that, why don't we move to the next slide.

Next slide, please. The recommendation is that EHR systems have the ability to electronically export and import medical record and administrative information across EHR vendor systems to enable users to switch EHR vendors without significant or material loss of clinical or administrative data. First off, we need to put in that patient centric view that Larry just described. Otherwise, does that seem like a crisp way of stating it? Crisp and complete?

Christopher Tashjian – River Falls Medical Clinics

Seems to be the case.

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

Agreed.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Next slide, please. Here, I just have one slide of Principles. That may not be enough, but why don't we go through—and some of this is pretty meaty, and we're trying to balance, as we discussed last time, how do you say something about what the scope of this thing should be without being overly prescriptive, noting that it could be very context specific how much information and what type of information needs to go.

The Principles I sort of grouped into three categories: Consistency, Content, and Time Horizon. Consistency was to say that we should build on the CCDA approach in alignment with the general high tech direction and perhaps—that's a question for us, actually. Perhaps consider CCDA templates specific to cross system data portability or something like that. We can just take off the question mark and just leave it like that if we're comfortable with that. I don't know that we want to prescribe that there be CCDA templates so much as maybe just throwing that out as an idea. It seems like the general approach is that the CCDA framework seems to be the right framework.

Dave Goetz – OptumInsight

You might just frame and examine whether it's CCDA template specific, yeah, examine, you know, rather than leave it as a question like that.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Yep, okay. Then in terms of content, what I tried to do is, again, trying to balance this *[Laughter]* how do you say how much is enough without saying exactly how much you think is enough. It should encompass all the clinically and administratively relevant information that can be reasonably transferred across systems without loss of essential patient, clinical, and administrative context or meaning, which I know is a mouthful. That might just give us at least a little bit of boundaries to the Standards Committee as they think about this, and perhaps give a little bit of indication of the type of configurability that one would want to enable as well. I tried to break this out into clinical data and administrative data.

I think, as we discussed last time, the Meaningful Use data set really, I don't think by any measure, would be enough. We had talked about the transition of care content and then Larry, you were talking about the content that you're developing for the, I forget what you're calling it, the TLC Plus or TCDA Plus or something.

Larry Garber – Reliant Medical Group

[Laughter] The Transfer of Care Summary.

Micky Tripathi – Massachusetts eHealth Collaborative

The Transfer of Care Summary, right. I think we decided that we didn't want to be so prescriptive, but I don't know how much more we want to say with respect to how much, how we cast the net on clinical content.

Larry Garber – Reliant Medical Group

Yeah, I'm not sure about the best way to do that, either, because there is so much overlap between the various consolidated CDA templates. I mean, clearly it's beyond what Meaningful Use says. The Transfer of Care Summary document includes full care plans and whatnot. I mean, fortunately, for users of it, most of the data fill ins are not required, but at least there are buckets to convey the information—

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Larry Garber – Reliant Medical Group

I'm not sure what the best way to convey it in here is.

Dave Goetz – OptumInsight

Are we assuming that this would be backwards compatible in the sense that if there were something that posed a question of interest to the receiving provider, they could go back and ask for a more extensive set of data around a particular issue?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. You mean, once it's in my EHR, I want to be able to go backward in time to a point prior—

Ted Kremer – Cal eConnect – CEO

I want to be able to contact—if you send me something and I see something in it that I think it's not complete or I want to know more about the history of this particular condition or issue and I can then send back to you and say, "Because I see this here, you have it." The reason I'm saying it is, data retention or availability are kind of implications for that.

Larry Garber – Reliant Medical Group

Yeah. That gets into the—that's interesting. It gets into sort of the other piece, which was the targeted query for patient information. We were basically generically saying, "Send us information," but it seems like, for Meaningful Use Stage 4, we may want to add the functionality for specific types of data requests. Give me information about this patient's back pain or their coronary artery disease.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. It's also dependent on the use case. The use case that at least I was implicitly assuming was, I'm a provider moving from one system to another, so there'd be nothing to look back to in that use case, but for your patient centric use case, Larry, there would be live EHR data, presumably, still being retained in some measure by the original source system.

Larry Garber – Reliant Medical Group

Right, so I see that querying for information really more part of the other, our other certification criteria about querying for patient information.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, right. Suggesting that we don't need to call it out separately, because we've got query, it's based on CCDA construct, so that ought to be covered there.

Larry Garber – Reliant Medical Group

I do like the idea of putting it on our agenda for when we start talking about Meaningful Use Stage 4, because I think there is value in saying more than just, "Send me records." I think at some point there will be value in saying, "Tell me more about this particular problem," as was suggested.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, right. Why don't I just note, I can note here, and we can put it there somewhere that we did notice this kind of backwards compatibility use case and we think that it is generally covered by a query and where the query transactions could lead us.

Larry Garber – Reliant Medical Group

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

The other thing that I was thinking of in terms of scoping was, again, it's hard to really get your arms around it, is what are the data elements required for the CQM and the decision support that I have enabled? Again, that may be a subset or sort of a partial overlap in a Venn diagram sense with what's in the Transition of Care template or Transition of Care summary, but if we included all of the data required for every numerator and every denominator and every exclusion criterion of all 64 measures and growing, we'd have a pretty big list.

Larry Garber – Reliant Medical Group

So when you say structuring of data, does that imply that numeric data won't be converted into text?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. That's what I was getting at, there. Don't take—you know, I've got five structured fields and you give it back to me as one text blob.

Larry Garber – Reliant Medical Group

I'm wondering if the term discrete data may—

Micky Tripathi – Massachusetts eHealth Collaborative

If structured data is discrete data? Yep.

Dave Goetz – OptumInsight

I thought "text blob" was a technical term.

Larry Garber – Reliant Medical Group

We've got something called a BLOB server and, you know, it sounds technical to me.

Micky Tripathi – Massachusetts eHealth Collaborative

[Laughter] We've got the grabber and the BLOB server. Then on the next bullet point, the retained structure context of notes, kind of what I was getting at there was, you know, if I've got a text blob in one part of my SOAP note, don't again merge it with all the other ones to give me one enormous text blob. I need to have some sense of what was it referring to or in what context.

Then the last one, I should, I do need to include the audit trails here, so I forgot to put that in, so I'll put that in. Then the last one, again, I forget whether we talked about this, was I've got; I may have a whole slew of attached documents. Is that asking too much?

Christopher Tashjian – River Falls Medical Clinics

Who's going to look at all this stuff?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. Well, that's a good question. We did talk about that. Some providers may feel like, "You know, I don't want all that stuff."

Christopher Tashjian – River Falls Medical Clinics

Not only do I not want it, I find it undesirable.

Larry Garber – Reliant Medical Group

Well, it depends on—go ahead.

Christopher Tashjian – River Falls Medical Clinics

Go ahead, Larry. I was just going to say, if I get a stack of paper from another clinic and it's three inches thick, what it means is, I'm not going to look at any of it. I'm going to look at the first two or three pages, but the amount of time it takes to look through and sort through it is just not going to happen.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, but most of this data portability is referring to when you decide that you don't like your current EHR and you as a provider want to go out and get a new one; that you can take your old records and move them into a new system. I think that's really what most of this data portability is about. It does enable some other use cases, but the primary one is so that you're trapped with your EHR. I did this move seven years ago now, eight years ago—time flies—anyway, from a legacy system to a good EHR. I moved one hundred million records, and we moved it all, which reminded me that one thing we forgot in the background is that, because I moved it all, it enables us to do research that includes that older data. There's another value, besides medicolegal and clinical and all that stuff, is to support research.

Larry Garber – Reliant Medical Group

Right.

Christopher Tashjian – River Falls Medical Clinics

That makes more sense for that purpose.

Larry Garber – Reliant Medical Group

Chris, let me ask you, when a new patient comes to you, so they've been at a PCP and they decide that they've heard great things about you and they want to come to you instead, and you know that they have a huge stack of records, would you prefer to have those records come along? Even though you may not read every one of them, but just so you know that you've got the complete set, or would it be like, "Eh, just leave them there; I don't really care"?

Christopher Tashjian – River Falls Medical Clinics

Well, I would not want to go to extra work to have them transported. I mean, if they're there, fine; I guess I'm not going to say don't send them, but if it's going to take a bunch of extra work, I'd say don't go to the bother.

Larry Garber – Reliant Medical Group

[Laughter] Okay, and I'll tell you my perspective. What we have is, we have a policy where when we get this stack of records, we have somebody from our Medical Records Department, and there's specific things that they look for. They're looking for imaging studies and EKGs and other studies. They're looking for immunization records, family history, things like that.

There's certain things that they flag and will automatically scan and index into our EHR. There's some things like the family history where they'll abstract it, actually type it into our system, and then they send the chart to me after they've done all that, and they say, "This is what we've done, and I can do whatever else I want to do with it," so I can sort of scan through that, I can see if there's anything else I want scanned or entered into my system. It doesn't all get entered, but it—and I mean, I do tend to try to look at most of it, but some of it you can summarize and flip through faster, but we do take a lot of it.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. So I guess, going back to the flexibility, would this suggest that we—we kind of leave it in for those who would want to take all of it, but again, this is a certification requirement, so it doesn't mean that, if Chris was going through this, that he would have to take it. He could say, "You know, I don't care about"—

Christopher Tashjian – River Falls Medical Clinics

Yes, I think that's fine. Again, I—going back to Larry's point, I like the idea that if we're changing systems, then I may want, there's more that I want, because it's stuff that we generated.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Yep, right. Okay. At least on the clinical data side, I think we still would love to get a little more thought and I'm just not coming up with any ideas on how to scope the clinical content piece of it, aside from saying it should be more than the Meaningful Use dataset. *[Laughter]*

Why don't we move—

Larry Garber – Reliant Medical Group

Well, actually, before you leave that—so when you're talking about attached documents, are you really talking about scanned documents, document images?

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. I mean, those could be a part of them. Yeah.

Larry Garber – Reliant Medical Group

Right, because I think that that's something to consider. There are scanned advanced directives that are important in that category.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, yeah, so I was considering everything that was attached. It would mostly be PDFs, I think, that are coming in, or that people have scanned.

Larry Garber – Reliant Medical Group

Right, but you may—I don't know if the word "attachment" automatically conjures up those images or not.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay, so why don't I add an example—

Larry Garber – Reliant Medical Group

Exactly, yeah.

Micky Tripathi – Massachusetts eHealth Collaborative

- of scanned documents, et cetera.

Larry Garber – Reliant Medical Group

Yeah, like scanned advanced directives; that's a good one.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, that's like a hot button one, too.

Larry Garber – Reliant Medical Group

Exactly.

Micky Tripathi – Massachusetts eHealth Collaborative

Directives and—

Larry Garber – Reliant Medical Group

You get extra points for that one.

Micky Tripathi – Massachusetts eHealth Collaborative

Exactly. *[Laughter]* Okay, and let's see—why don't we go to the administrative data and think about that, maybe. Oh, no—back. As administrative data, again, what I put, it's again hard to get your arms all the way around it, but retaining some of the claims transactions for a reasonable time period covering the transition—again, I don't know.

I think in the last call, we had some people saying, “I really don't need most of that.” I think, Larry, you had described how there's a reasonable time to cover your days of AR, but after that, no real need. Then, similarly, how much scheduling and appointment information would be reasonable. Actually, I should have put patient demographic information, but that would be, you could put that in the clinical side as well. I guess we just make sure we want to have that captured there—but insurance information, all of that, you want to make sure it's coming over.

Larry Garber – Reliant Medical Group

Right. Yeah, I would call out demographic and insurance, because those are, it's more likely that those will be kept—I think what we did is, we did a cut over with the claims at some point. We kept the old system running to finish up the billing and everything; then, after a certain day, it was on the new system.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah.

Christopher Tashjian – River Falls Medical Clinics

That's the best way.

Micky Tripathi – Massachusetts eHealth Collaborative

Right, yeah. Okay.

Larry Garber – Reliant Medical Group

Then I think we had talked about audit trails as potentially—

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, yeah, right. Yep. Yeah, and what was that conversation? I'm just trying to remember—

Larry Garber – Reliant Medical Group

It was for medicolegal, *[Cross talk]* it was for medicolegal purposes because if I'm called in on a lawsuit several years from now, they're going to want to know what I saw, when.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, yeah—no, it was, I think it was the metadata part that I was just thinking about. Did we—I thought you said metadata, or did you say medicolegal?

Larry Garber – Reliant Medical Group

I was saying medicolegal.

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, okay, good. All right, good.

Larry Garber – Reliant Medical Group

I think the metadata is—I might have also said metadata because, in a way, it's kind of metadata. That's what the lawyers are asking for when they subpoena now is, they ask for metadata, that's a word they use.

Dave Goetz – OptumInsight

Oh, boy.

Micky Tripathi – Massachusetts eHealth Collaborative

Wow. *[Laughter]*

Larry Garber – Reliant Medical Group

And we want to get rid of the metadata if we can.

Dave Goetz – OptumInsight

That's where they have all the fun. That's—yeah, boy.

Male

That's the stuff that hangs you and you're not even aware it's going on.

Dave Goetz – OptumInsight

Mm-hmm.

Larry Garber – Reliant Medical Group

[Laughter] All right. No comment on that. *[Laughter]*

Dave Goetz – OptumInsight

I'm no longer the designated jailee for Tennessee, and it's a real nice thing.

Micky Tripathi – Massachusetts eHealth Collaborative

[Laughter] Why don't I just cover the Time Horizon, which is the last thing on this, and then see if we have any concluding thoughts or final brain ah-has on the clinical data.

So, on the Time Horizon, I wanted to just note that there's probably something related to a user configurable setting of the time period to cover legal medical record retention requirements as well as to support look back periods for decision support, CQMs, care management, what have you. I think, Larry, with your patient centric thing, there's also that element of it as well.

Larry Garber – Reliant Medical Group

It would be nice, if we're making a system that can export it and that can import it, it would be nice if we could do a patient slice.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep.

Larry Garber – Reliant Medical Group

While you're there. *[Laughter]*

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, I'll add that in. I like the framing of that patient centric/provider centric, because I think that gives a nice, intuitive way of thinking about how data portability has a lot of different dimensions.

Larry Garber – Reliant Medical Group

I know, and as I think about how if, God forbid, I ever had to switch from my current EHR, that I know that there would be certain types of encounters that I would move and not necessarily others. I know some people would want to do office visits but not telephone calls, for instance. I'm not sure how that filtering would be specified here.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. It would be by encounter type or something?

Larry Garber – Reliant Medical Group

Right.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep. Okay, why don't I add that as well? I think that might have been Kory, in your initial draft, and I might have somehow just lost it along the way.

Dave Goetz – OptumInsight

I've got to hop off, guys; I'm sorry.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. That's all right. Before you leave, what's your brainstorm on clinical data? Let's go. *[Laughter]*

Dave Goetz – OptumInsight

I think, truly, we've done okay.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Dave Goetz – OptumInsight

My brain says, “Leave it alone.”

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Dave Goetz – OptumInsight

All right. See ya.

Micky Tripathi – Massachusetts eHealth Collaborative

All right. Thanks a lot, Dave.

Christopher Tashjian – River Falls Medical Clinics

Unfortunately—this is Chris—I have to leave as well, but thank you.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. All right, great. Thank you.

Larry Garber – Reliant Medical Group

I can stay with you, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. *[Laughter]* Who else is on the call—Ted? Ted, I don't know if there's anything from, you've got the Rochester RHIO there in terms of what you're seeing as being kind of the core elements for a repository type, RHIO. Is there anything that we can learn from that that would help us think about what's the scope of clinical data that we ought to think of as important?

Ted Kremer – Cal eConnect – CEO

Well, I think—I mean, you're getting into a lot more detail than what we pass through the HIE, so I don't know that we would inform that so much. I think the bigger issue you raised, I think, is critically important, which is, we are sort of seeing that incipient market turn already, so I think it's a really important topic.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Okay. Okay. Okay, well, it seems like it's a pretty solid recommendation that I think will be seen as quite helpful and the only thing that's still outstanding is this clinical data thing. Maybe one of the things we can do is turn around the next draft and throw it out to the group, and we should throw it out to the group for their final blessing anyway, but I can highlight that and see if others have a thought around that.

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

Yeah. I mean, I think you could—this is Kory, Micky—you could leave it to the Standards Committee as well if you feel like the group doesn't come to a specific idea around what it should be. I think it could be part of the tee up to the Standards Committee potentially as well.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Right, right. Yeah, I think that is how we left it last time, was to *[Laughter]* kick it over to them.

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

Yeah—always a fall back.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. *[Laughter]* We'll let John Halamka know what's coming.

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

[Laughter]

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Great, well, unless—are there any other thoughts on either the provider directory or data portability? Because otherwise we can end early and give you back 40 minutes of your day.

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

I'll take that deal.

Larry Garber – Reliant Medical Group

I think this is all exciting stuff, yeah—including the time back.

Micky Tripathi – Massachusetts eHealth Collaborative

Including the time back. *[Laughter]* I'm excited by that, myself. Okay, great. Well, thanks, Ted and Larry.

Larry Garber – Reliant Medical Group

Wait, the public; do you have to do the public thing?

Micky Tripathi – Massachusetts eHealth Collaborative

Yep, and then we'll turn it over to Michelle for the public comments. Michelle?

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

Oh, I know she had to step away at one point, so I'll try and do that. Operator, can you please open the lines for public comment?

Public Comment

Ashley Griffin – Altarum Institute

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no comments at this time.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. Even data portability didn't get a public comment, *[Laughter]* of all the exciting topics. Okay, great. Well, thanks, everyone, and we'll talk soon.

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

Thank you.

Ted Kremer – Cal eConnect – CEO

Thanks, bye bye.