

**HIT Policy Committee's  
Information Exchange Workgroup  
Transcript  
July 22, 2013**

**Presentation**

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Good afternoon everybody, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Information Exchange Workgroup. This is a public meeting and there will be time for public comment at the end of the meeting. Please remember that the meeting is being transcribed, so please announce yourself when speaking. And I will now go through the roll call. Micky Tripathi?

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

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Amy Zimmerman? Arien Malec? Charles Kennedy? Chris Tashjian? Cris Ross? Dave Goetz? Deven McGraw?

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

Here.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

James Golden? Jeff Donnell? John Teichrow? Jonah Frohlich? Peter DeVault?

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Here.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Larry Garber?

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

Here.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Stephanie Reel? Steven Stack?

**Steven J. Stack, MD – Chairman - American Medical Association**

Here.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Ted Kremer? 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 for Health Information Technology**

This is Kory Mertz.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you Kory.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Elise Anthony.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi Elise. And with that, I'll turn it over to you Micky.

**John Feikema – Coordinator, Standards & Interoperability Framework - Office of the National Coordinator for Health Information Technology**

John Feikema from S&I Framework.

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

Okay. Great. Well thanks everyone, thanks Michelle, and welcome everyone to the Information Exchange Workgroup meeting. Today we're going to review the presenta...or the results of the presentation that we gave to the Health IT Policy Committee, which I think was very well received and we have one small issue to work through coming up from the feedback from that meeting. But overall, I think the meeting seemed to go very well. And then we want to dive into the data portability conversation, which is the remaining sort of recommendation area that we as the Information Exchange Workgroup were...are sort of on the hook for as it relates to the Meaningful Use Stage 3 recommendations that we are primarily responsible for. So, why don't we move forward then with the slides and we can walk through that.

Next slide. So the...yes, let me back up for a second. The Policy Committee did approve the query for patient record recommendation. I think the conversation was a great one and it seemed to be very well received and I think what seemed to resonate to me, but I'd love to hear from others, particularly Deven was at the meeting and she is on the Policy Committee, but any others who listened in. But a couple of thoughts...a couple of pieces that I think seemed to resonate well with the Committee were one that we are very aligned with the work of the previous...of the Privacy & Security Tiger Team and a lot of the work that they've been doing. So I think that alignment always helps from a Policy Committee perspective, to the extent that even if you're not fully aligned, at least you recognize and point to the areas where another workgroup has already done some work, so that they can have a sense of how to vet it.

But in this case, we were, I think, perfectly aligned with the Policy Committee, so I think that that seemed to help a lot. And I think to the extent that we were speaking...trying to react to the feedback and the lessons learned that we had had over the last couple of years really, in some of these areas. And trying to step back and say, how do we give some direction that can move us forward, lay a stake in the ground for query types of transactions and provider directories in Stage 3. But still leaving a lot of room for getting enough traction and enough guidance that it'll move us forward, but also on the other hand, leaving some room for flexibility and innovation, I think, which is as I think all of you know, is an ongoing concern from a policy perspective.

The Policy Committee also approved the provider directory recommendation that I think was similarly well received, but asked us to re-look at one particular point that we had in there, which was related to authentication for those who are going to access a provider directory from another entity. So, that's the first agenda item on our list here today, is just for us to take a look at that and just have some discussion around that. And we have, is it John from the S&I Framework team?

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Yes. John Feikema.

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

Okay. And so we've got John from the S&I Framework team who can give us a little bit of context for what they're thinking about in the S&I Framework team to make sure that we have a full understanding of that, as we think about this particular issue. But let me first open it up and see if there are any other comments from the Policy Committee meeting itself for any who were there.

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

Micky, it's Deven. I think you characterized it accurately. It was also on the phone, which can actually make it harder usually, because you can't really read people as you're making your presentation. But sometimes it actually means that the amount of dialogue ends up being kind of naturally constrained to really only the sort of most critical issues, if that makes any sense.

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

Yeah, yeah.

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

...people, so the people talk less.

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

We should think of that strategically and tactically going forward.

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

It is something to consider, that's for sure.

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

Okay. Great, unless there are any other thoughts, why don't we dive down into this authentication question. So next slide please Michelle. Next one. So, I think here we have the full set of slides related to provider directory, so let me...rather than going through each one, because I think all of you have seen these, hopefully. These were...this was the subset that we presented at the Policy Committee. So, next slide please. This was the basic recommendations about search and providing a provider directory, and then we talked about the guidelines that...which was sort of principles and then...that sort of underline the recommendations.

And then I think on the next slide is perhaps where we...right, so it's on the next slide where we sort of spelled out the transactions in particular that would essentially form the basis for the provider directory types of transactions we were talking about. And it was on the slide...it's on point B, number 1, well I guess it was...it's A number 1 and then B number 1 where we put in there as a set of kinds of specifications or characteristics that we were recommending be a part of these transactions. Or whatever standard comes out with respect to these...transactions, that there be an authentication loop that essentially that whoever is the querying system of a provider directory ought to present some type of authenticating credentials is the way it was written here. And that the provider directory, the holder of the provider information as it were, the receiver of this request would have some ability to validate the authenticating credentials of the requesting entity.

And it was that particular point that raised a little bit of concern about the alignment of this with the current direction of the S&I Framework in particular, which I think John can...will be able to speak to a little bit. And both Farzad and Doug Fridsma, I think, asked that we just take a look at that again and think about it within the context of the S&I Framework and then come back to them at the next meeting. The only thought I would offer before we dive into that...well, maybe we should open it up for others if you have any initial thoughts. And then we can ask John to talk a little bit about the framework, is that it's certainly possible, I think, because as I was thinking about the origins of how we did this, that perhaps this is over-specified to the extent that it talks about as a part of the transaction, presenting authenticating credentials and then validating those authenticating credentials. So, I think that there may be scope for us to have a conversation about that with respect to the particular language of our recommendation.

On the other hand, I think it is...certainly seems to be the case as we've seen the market unfold and I've reached out to a number of people who are involved in different places and people on the Standards Committee as well, who have all noted that at least in the way that the provider directory concept is unfolding right now, and particularly as you think about this being within the context of certified EHR technology, so within the context of HITECH certification, which would mean that in many ways the first set of...or at least the first...the most proximate provider directories people can think of are the provider directories that might be contained within a complete EHR. That as we've seen those start to emerge in the wild, whether it's part of an EHR or part of HISPs, they almost always seem to be offered or exposed as a part of some kind of trust fabric. That perhaps it isn't in a particular transaction for...provider directory transaction that you're...literally, in that transaction presenting authenticating credentials.

On the other hand, I certainly know in Massachusetts where we've got the statewide provider directory that is now live and rolling out, the on...you have to be a member of the trust community of the Massachusetts statewide HIE trust community in order to be able to access that provider directory. So...and we're seeing that in many other places as well. So it may be that a part of what we might want to think about is...a background consideration that says that as we're looking at this authentication can be an issue, particularly as we think about the concern that provider organizations have about spamming and other possible misuses of information that is contained within a provider directory that has the EP and EH level information, which was a part of our recommendation here. So just offer that as general context here, but let me open it up to any members of the workgroup who have any initial thoughts and then maybe we can turn it over to John, who can tell us a little about the S&I Framework background on this.

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

Sure, this is Larry. I agree that as we thought about this it was the difference between a public directory versus a private one. We felt that there was going to be an important role for private directories and that the functionality needed to be in place to support that. It doesn't mean that directories can't be public, but that the certified technology needs to be able to support a private directory.

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

Right. I think that's a great way of framing it. Okay, unless there are any other thoughts, maybe I can turn it over to John then for a description of a little bit of background on the S&I Framework and any other thoughts John that you have. And thank you, first off, for joining this call on pretty short notice.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

No problem at all. One piece of clarification might help in Larry's last comment, was the certified technology in that case, meaning the EHR or the certified technology meaning a provider directory itself being certified, since it's the...since as I read these recommendations, you're really talking about what the...are you talking about the need to be able to present a credential or the fact that the provider directory requires one?

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

Well Micky, I don't know, do you want to talk about federal levers as to what we're allowed to regulate?

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

Yeah, so we've been doing this...this and the query recommendation that we made were all within the context of the HITECH statute...

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Right.

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

...where the idea...right, and so whether it's a standalone provider directory that's seeking certification or if provider directory certification becomes a requirement and its presented as a part of a complete EHR, I mean in thinking about in that context, I mean I think you have to think about it with the same requirement in mind, right, whether it's a...

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Right, which is...

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

...I'm not sure if that's getting at your question.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Well, I was thinking about a role in the ecosystem if you will for a standalone provider directory that's not a part of an EHR that's a...it's too bad Jim Golden's not on today, I'm from Minnesota and I'm familiar with what is being put together here. And I know that the provider directory that's spec'd and being put together, if you will, is a service that's offered by the state or the state specified HIE and it's not a part of...and as a result, it's not a part of the certification process. So, there are...I mean the state may choose to certify it, but it's not a part of HITECH certification, so that does limit the kinds of things we can do.

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

Right, so but then I guess getting back to core question then, is if it were to seek certification of the type that we are recommending, would we want to make some type of membership in a trust fabric or authentication...other types of authentication be a part of that? Right, that's...it think that's the context here.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Yeah.

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

Yeah, Micky, this is Amy. And I've joined and I don't know what Jim and they are doing, but I've mentioned this before that I think that we're using provider directory in a couple of different ways here in terms of its semantics, and how much of a...and what incorporates the directory. So I think somehow we just have to continue to do the framework and framing the issue. Because again, in Rhode Island we're talking about building one, but more as a service, whether it's run by the state or another entity, for other state systems but eventually potentially having a portal for public access. So it would be from what private and public and it's as much to link providers to practices, as it is to give information about direct addresses and contact information. So, it's multipurpose and its broad and I'm trying to figure out...I've raised this a couple of times, like how does that context fit into here? And that's what I think I hear perhaps...I mean I know in Massachusetts it's a little bit more defined around the HISP and Direct, but I don't know about Minnesota.

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

So Amy, just let me ask a clarifying question. So...well, let me make an analogy and then ask a clarifying question. So in the analogy, I mean I think that we...if we think about this similarly to any other type of modular certification associated with certification, then whether it's separate or a part, you'd still have to meet the same standards. So, if you are seeking certification for the purposes of HITECH, right. Now you don't have to, but in the same way that we have clinical data warehouses that are out as standalones getting certified, they may do lots of different things, but there are certain things that they have to do if they're going to be certified for the purposes of HITECH, so that a provider can use them as a part of their...the technology that they want to attest with. But that doesn't mean that they don't ten other things and it might be that they do ten other things, but the one thing that they do that relates to certification, they have to make sure that they meet the certification requirements for that one thing.

So that's the analogy, I think that would be sort of the same here with the provider directory. You could have provider directories that are standalone that are doing multiple things, but if they want to be certified for HITECH, they've got to make sure that they've reached...that they are achieving that baseline for the set of functions that they're offering as being certified for the purposes of meaningful use. Then the clarifying question Amy, is the provider directory that you're constructing in Rhode Island, is that open to anyone, including the Direct addresses at the individual level?

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

Well, we haven't gotten that far in discussion, so again, whether there are some components that are open to the public and some aren't. I mean, this started with a conversation around the fact that we potentially would be building several provider directories and large state systems, including the benefits exchange and our HIE and our APCD, and why are we going to do this four times, five times, however many times; let's do it once as a comprehensive, statewide. There is a lot of interest in making at least some of that information available to the public, but we...through a portal, but we haven't gotten...we're still trying to work on making this clear to state officials and state principles and getting executive level sponsorship and potentially putting this into our SIM test application and stuff.

So, we're very early down the road, so I mean I think we would have to clearly wrestle with sort of what is public information. I don't think...I don't know that we would want Direct addresses being out on a portal available for just anybody, for some of the reasons you said. But...so, we haven't thought that through yet. I'm just rais...I was just raising it because...only because of the comments before about how broad or how narrow, and to some extent, if it becomes...it's like some other components, if it becomes part of a requirement under HITECH for EHRs, which is fine, then typically all the EHR products are going to do it. And providers may not...EHRs may not rely on the kind of provider directory that I'm talking about, unless there's some other advantage that is not happening within the EHR, which is fine, because again the intent was for something slightly different, really to minimize having to build this ten times over and at least maintain and update it with good information once and not multiple times.

**M**

And the way...finish, go ahead.

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

I'm done.

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

I mean, so the way I look at this is that the HITECH Act allows us to build trains and it allows us to build some of the rails, not too many, but a few of the rails. And so we're going to define the gauge of the trains and we're going to build a few of the tracks and we know that there are going to be tons of tracks built with these large state provider directories and other community directories that are standalone. And what we're hoping, I guess, is that since we built...we're defining the trains, we're building a few of the tracks, we're hoping that the provider directories that are built separately will also build the same tracks that conform to the ones that we've specified. And I think that's how...at least that's how I look at this.

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

Yeah, I'm not disagreeing. I can't answer yay or nay to that because I think it's too early to know in ter...I mean I think ultimately we would want to try to make and use as many...use the same standards all across. I just think that the term, like I have to do a presentation to the Executive Committee of our Healthcare Reform Commission on Thursday and I'm sort of using the term in one way, and so I'm always trying to fully understand and digest and then we can move on. I don't want to dominate the conversation here, the fact that its more narrowly defined and where some of the functionality will sit and rest in other places. So, it's just a challenge from a...

**Micky Tripathi, PhD – President and Chief Executive Officer, Massachusetts eHealth Collaborative**  
Sure, so....

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

...multipurpose and definition point of view, and different visions.

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

...so, I understand, but I guess I would just like to just remind us though of what we are discussing now because all of this...everything was approved by the HIT Policy Committee here, so I don't think that we...that right now, for this call, we don't need to talk about the principles anymore in general and about the alignment of it with HITECH certification, because that's already been approved. They've only asked us to come back and look at this particular, really A1 and A...5A1 and 5B1 are the two very specific points that they've asked us to look at again. And Amy just from...just drawing the thread on what you just said when you suggested that you would feel discomfort about exposing individual provider level information with their cor...or EH information with corresponding Direct addresses is suggestive that you do support some type of principle related to authentication. Now again, we don't necessarily have to say that that should be a part of a standard. We could note, I guess, I mean just offering alternatives here, we could note that there does seem to be a fair amount of concern out there about just exposing that kind of information in the public and where we're seeing it implemented, there does seem to be some type of trust fabric that's built around it. It seems like that's another question for us is whether we want to recommend that that be a part somehow of the standards or the standards framework or that we note that it's something that seems to be of importance and then remain silent on whether it ought to be a part of it.

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

I see what you're saying, because we're being very specific by saying presenting credentials...

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

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

...whereas really what we're just trying to do is asserting trust or something like that.

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

Right, exactly, and you could almost even say that that's the way it seems to be happening...that's up to an individual provider organization whether they want to expose it as...generally to the public or as part of some kind of trust fabric, you can leave that out of the particular standard.

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

Yeah, I guess part of what I was reacting to Micky was sort of its h...again this sense that some of the information may be available to the public and some may not. So leaving it in a way that the credentials or authentication can be flexibly implemented I think is what would be important. I mean, I don't know where we would come out on that and I don't know whether we would or we wouldn't want Direct, addresses open to the public. I think it would...we'd have to really think that through and discuss it and...whatever. But I'm trying to...my point was more in terms of flexibility because there may be parts that we don't feel we need that for that it's okay and perfectly fine to expose to the public.

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

Right.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

So maybe one piece of clarification might help here...this is John Feikema again. I think there's a...I think one of the reasons that I hear frequently people suggest that we don't want to make Direct addresses available or visible to the public is because of spam. But I don't...I think it's important not to conflate visibility of an address or even availability of an address with the existence of a trust relationship. Meaning, just because I have your Direct address doesn't mean that...and I send you something, doesn't mean that you're going to receive it from me, unless our trust bundles have been shared, unless we are a part of the same framework, unless there's some other trust mechanism in place. So spam really isn't an issue for Direct, I mean, the way it has been put together, that should not be an issue.

Now that doesn't mean that all Direct addresses need to be exposed to the public, but the most common reason I hear that they shouldn't be is because they're worried about spam. And the establishment of the trust relationship and the lookup of the credential are not synonymous and there is, built into the applicability statement, mechanisms for making sure that spam doesn't happen. And it was in this...in that sort of context that I had a conversation this morning with...Catherine from California as part of the California...actually part of NATE or what used to be called Western States, but also represents the California Consortia and they've been debating this issue for some time. This issue meaning should the exchange with a client and a provider directory be mutually authenticated or just one directional. And they...the California group has landed on the fact that they believe that it should be single-sided authentication meaning, the client should be presented with a credential from the provider directory so that they know that it is a source of truth. But that the querying entity does not need to present a credential to the provider directory in large part because they want to make it possible for people who aren't yet a part of that trust fabric to establish that relationship, not just through the lookup but by contacting people and being aware of them. And they're trying to lower whatever barriers are possible toward exchange and they view that as one of the mechanisms for doing that. In some respects, the very fact that you're looking up an address says that you don't know who that party is and you haven't yet established trust and yet if you haven't established trust and we require authentication, then it makes it problematic for them to get connected.

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

See, but I think Amy brings up an interesting point, which...so even if you are...okay, Direct address let it go because no matter what, that doesn't mean that they're going to be able to get through and spam us. But provider directories have other purposes and maybe there's going to be a back office phone number line that's part of the information in the provider directory and we want to be able to say, okay to other providers I will give them my back office number, but I don't want the whole world to know my back office number. So in order to do that, I have to have some authentication of who it is that's doing the query so I know what to respond to them with.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Yeah and I'm not suggesting that a provider directory can't choose to require authentication in order to expose certain things, the question is, do we want to require it in order for people to connect. The original HPD specification that most of the provider directory worked that I've seen these days is built on, really doesn't have sensitive information as a part of the data model. I mean, most of the information in there would take you a while to get, but most of its available via Google. Now if we're going to start putting stuff in there that we want to be private, then allowing a mechanism by which that can be protected I think it fine, the only question is do we need to require it.

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

I'm not sure that...I mean, maybe Micky you can confirm, but I don't think we're requiring something here, I think we're requiring that the EHR has the capability to support this, but that it doesn't...does this mean that they have to use it?

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

Right, I think that's a great point Larry, is that this doesn't require that they have to use it any more than any other certification requirement says that they have to use it. Unless it's specifically named in the meaningful use...on the CMS side, with respect to the meaningful use behavioral requirements. So this is really a certification requirement that would say that the technology has to be able to do it, should a user want to do it.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Yup, I see that now.

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

Which I think is...and I'm glad you raised that Larry, because I think that is an important...a very important point here, that that's...that is at the end of the day all this is saying, because it is focused on the certification side of this. And I think we do say, my thing is frozen here, we do say that this is not about a meaningful use recommendation per se, these two, the query and a provider directory are purely about a technology certification requirement.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

So perhaps the way that this is positioned then is since we haven't, and these are my words, I'm not trying to put them in anybody else's mouth, but a way for me to take back sort of a synopsis of this might be, since we don't yet know all of the various ways that provider directories will be deployed, and especially since we haven't figured out all the business models and which of those are going to be most effective, and because some of those scenarios may involve exposing information that we do not want to be public-facing, we're going to...the recommendation is that these capabilities exist so that in those cases where we need to protect information, we have the ability built-in to the systems that are certified.

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

Right. I think that was well said. I'm going to bring you to the next Policy Committee meeting.

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

Now I'd like to...but you also brought up a fantastic point, which is whether there should be support for bidirectional authentication. In other words, should the receiver, as part of our certification criteria, that the receiver is able to...the querying system is able to authenticate that they received this from a valid provider directory.

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

Right, right, because that's not in here. Right.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

In some respects that's more...well, I don't know, depends on your perspective I suppose, but if you want to be able to count on the veracity of the information, it would be good for the provider directory itself to present credential to the end-user, the querying system.

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

So that would be A4 and B4.

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

I can't wait to go back and say Farzad, we've thought about it and we've doubled down on the authentication requirement.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

You can leave off that I assisted...

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

You're going to make some authentication vendors very happy.

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

Yes.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Fortunately one certificate on a provider directory is in the noise and frankly, every...assuming that a querying system is the one that has the Direct capability. And that's kind of the rub here is that if it's the actual HISP or the STA more specifically or the system that is Direct enabled that is doing the querying, well then they already have a credential, I mean, they have a certificate...I mean they have a Direct certificate or they wouldn't be using Direct. Right, so it's not that hard for them to present that, but if there's a third party system that's doing the querying on its behalf, and presenting that information or making it available to the STA or whatever, now we're adding complexity to what it needs to do.

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

Um hmm. I wonder, is Peter DeVault, are you still on the phone?

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Yeah, I'm here.

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

I just wanted to see if you had any thoughts on this, particularly regarding these...the bidirectional, unidirectional authentication, given that you've got provider directories that might have to meet these requirements and what you...sort of how do you think about this within the kind of security frameworks that you're setting up?

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Well, I think we can probably be silent on this issue and just let different ecosystems, if they feel like they need that kind of authentication because they're composed of multiple pieces from different organizations, do authentication. But if it's perhaps something more self-contained, that might be unnecessary.

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

And do you have a particular problem with the bidirectional versus unidirectional or it's just that you're going to see a lot of variation...if I'm understanding you correctly, there's a lot of variation in the market and we need to recommend something that allows for that variation to...

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Exactly, I would say allowing the greatest level of flexibility at this point is the right thing to do.

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

Right. So in a way, allowing that flexibility would suggest though adding the bi-directionality, right, because that would then say that you want that to be a part of it so that people who want to do it will have the option of doing it and that if we don't say it, they may not have the option of doing it.

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

That's a good point.

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

How do others feel about that?

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

Sold.

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

Any objectors? Great. John, what are you doing at the HIT Policy Committee meeting?

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Which one?

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

August.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

I...I'm trying to remember, what date is that one?

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

I'm joking.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Well, one of the next ones, I don't know that it's this...I think it's in the September one, I think I'm going to be there in person because I believe Doug is out of the country, so I may actually be presenting. But...

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

Okay.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

...I'll be listening in the background, I'll be lurking in August.

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

So it sounds to me like where we've landed here is that a) really sort of confirming and reminding everyone...I guess I should say it that way, reminding everyone that this is about a certification requirement, this is Larry's point, which I think is a great one to keep reminding ourselves of, it's about a certification requirement. And so we just want to make sure that technologies have this capability for those who want to use them, given that we're seeing that there is this concern out in the market and there seem to be enough users out in the market who would want to be able to use this to justify including it as a part of a certification standard. So that's kind of the first point and sort of in line with that sort of that logic, we'd want to be able to have that be bidirectional, so that both the clients as well as the owners of the provider directory have the ability to authenticate the other.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

And is it unreasonable to be explicit about the fact that at this stage requiring the use of those is not recommended as opposed to just leaving it to the reader to realize that there's nothing asking for that?

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

Well I guess the way I would suggest doing that is again within the context of just reminding everyone that we are not making a requ...we're not making any recommendation with respect to the use of provider directories. Because that gets us into the whole other realm, which I think in general we've been trying to move away from as a process, moving away from these kinds of process sort of measure sorts of things, if they use this technology ten times then you've checked off a box. We tried to say let's move away from that, allow people to focus on clinical outcomes and outcomes in general and ensure that from a certification perspective, we're putting in to place the foundation, the technology foundation that will allow them to do those things.

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

Speaking of that foundation...I do have a quick question regarding what S&I is looking at. Are they looking at the need to automatically...automatically update the provider directory from the EHR?

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

No. That hasn't been within the scope at this point.

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

Darn. Okay.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

We had our...we had some interesting challenges getting to this point and fortunately one of the things that the NATE group, the old Western States group is doing as a part of their pilot is they are looking at federation as a critical component. And we think that that will significantly raise the bar and will help connect these different things together, but that...we didn't go so far as to then go back upstream to the EHR and require that, only because that so completely defines what architecture needs to look like.

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

Okay.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

One last thing perhaps, Kory, if you're still on, the reason I asked that piece of clarification Micky a second ago is because when I was listening to this issue last week, it did not...I did not realize that what we were talking about was pure capability. And I sort of jumped to the conclusion, errantly, that what we were talking about was requiring this for use by a provider directory. Kory, did you get that impression, too or was I just not paying attention?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Um, I think people easily mix those together. I realized that, just from having worked on the workgroup, but I guess I should have been more explicit so that everybody...ensuring everyone else is on the same page on that.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Because I think if Farzad and Doug had had the benefit of this conversation, I think there would have been a lot less angst about it.

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

Right, right. No, and I wish I had said it, it just didn't even...I didn't say it and remind them on the call. But I think you're right, I think they probably would have felt more comfortable with that.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Okay, well I'll certainly pass that on.

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

Okay. If you could just take a picture of Doug's face though when tell them first that we've doubled down on authentication, just so I'm not around, that would be great.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

Yeah unfortunately and fortunately, he's out of the country, so, it'll be a little while before I have to do that.

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

Okay, great. Well thanks John for joining this has been very helpful.

**John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator for Health Information Technology**

All right.

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

Okay, great. So we will now move on to the data portability conversation, unless anyone has any final thoughts on that, but I thought that was a nice sort of encapsulation of where we are and I think will put us in a good position to clarify this at the next Policy Committee meeting. So, let me see, I'm just pulling up my slides again, my computer has frozen on me, so I'm just going to pull up the actual presentation here. So I think on the da...just reminding ourselves now on the data portability we did make...we presented some...sort of a, I'll call it a recommendation, but it was really for inclusion in the RFC, so it was really just to get an RFC question out there to be able to get comment on.

Maybe I'll...and so, what we want to do is sort of remind everyone, just level set us again about what it was that we said at the time. And what were some of the thoughts behind it, what have been the comments, and Kory's done a nice job here, I think, of synthesizing this, so I'll turn this over to him in a second, to ask if he can just walk us through this. And then I think what we want to do is come back to remind ourselves of where we were, what were some of the principles we were thinking about as we made that recommendation and are there any...is there any rethinking of that in terms of principles. And then also in terms of details, have we sort of changed our general view of that, which I think will help us set ourselves up for the next call where we'll discuss this in greater detail if necessary. So Kory, if you wouldn't mind taking over for the next couple of slides and just describing the synthesis of the comments you have here.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Sure, happy to Micky.

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

All right, thanks.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Great, so just as a reminder, the...so you know, we specifically asked about what criteria...the workgroup included in the RFC the question up above along with what was included in the Stage 2...the certification criteria around data portability. So specifically that is involved in being able to generate a CCDA that includes the minimum the common MU data set elements that are spelled out there. So that's kind of the base that we're working from from Stage 2. Then as far as comments go, we got 56 overall. The majority felt this criterion was important and they thought further progress needed to be made. I think this aligns with where we've seen the market go since then, I know Micky had this in one of the framing slides that we fused earlier around I forget if it was like 0-30% of providers are going to be looking to switch EHR vendors...

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

Yup.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

...over the coming years, so, I think that sort of...that data point certainly reaffirms that piece, and I think we heard that from the commenters as well, that they...that the majority thought it was valuable. There are certainly commenters who thought it was unnecessary or duplicative of other criteria, as far as the functionality. And then I think you heard from some that more data needed to be added for this to really provide that bang for the buck and the ability to really support portability between EHR systems. Next slide please.

So to that question of what other data types should be included, really got a litany of different data elements, tried to capture those here as best as possible, the various different types. So I think you certainly saw support from commenters to really build on the MU data sets, say hey, things that are added in Stage 3 should be added for this as well. I think some people raised questions around saying hey, we really need to make sure historical data is included that's going to allow for the generation of clinical quality measures. That could be something to think about as well there, that there seem to be a number of folks who are kind of thinking along that line and a little concerned around quality measurement. And then, I don't necessarily want to walk through all these different things, but again, kind of a long list of different areas that people suggested that they saw as important to add. But again, a lot of these where...didn't note some additional level of frequency, were maybe just mentioned a few times by commenters. Next slide.

And just a few other comments that came in. Again, these were fairly sporadic ones at this point, but I think the biggest ones were expressed before, but again, some people raising questions of is the CCDA really the way to go or should we be looking at QRDA and some other potential standards for really being able to facilitate the data portability. So I think those are the highlights and I think the most important piece is from the comments.

**Micky Tripathi, PhD – President and Chief Executive Officer, Massachusetts eHealth Collaborative**  
Okay, great. Thanks Kory.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**  
Um hmm.

**Micky Tripathi, PhD – President and Chief Executive Officer, Massachusetts eHealth Collaborative**  
So going to slide 12, and I'm sorry I'm not logged in, so if we could just go to that, I think it's the last slide. I guess there are just some overall questions, one is sort of at the high level, do we still agree that using the CCDA for data portability is the right one to build on, which is what was in the initial thing that we put out there for...in the RFC? And then a separate question, aside from the vehicle is what additional content should be added to the common meaningful use data set to improve the results of data portability. We have the common meaningful use data set, are there other things that should be added and I think what Kory has done here is list the other things that are not a part of the common meaningful use data set that were in the original recommendation that we had, is that right Kory?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**  
No, I'm sorry Micky, those are the items that are in the common MU data set.

**Micky Tripathi, PhD – President and Chief Executive Officer, Massachusetts eHealth Collaborative**  
Let me read that, oh yeah. Okay. Oh yeah, so they are.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**  
Just so we didn't have to flip back and forth.

**Micky Tripathi, PhD – President and Chief Executive Officer, Massachusetts eHealth Collaborative**  
Oh, okay. All right. So these things, if we recom...if we focused it on the common meaningful use data set, these are the things that would be included. I think one of the things that one can quickly glean from this is that there's no administrative data included, so to the extent that you have EHRs that are also integrated practice management systems and have billing, appointments, scheduling data in there that's not included in any of this. I guess there's a question of scope with respect to HITECH and what it covers, but it seems like that at a minimum isn't there. There's certainly other information like detailed notes that would not get included if we focus it specifically on CCDA related to common meaningful use data set and I'm sure there are other things that are left out of the CCDA construct in general. What are people's thoughts on this?

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Yeah, Micky, this is Peter, I'll comment on the first question. It does definitely seem to me that CCDA is still the right document architecture to be talking about so that we can take advantage of progress being made on EHRs ability to consume those kinds of documents.

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

Okay. Do others have thoughts on that?

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

This is Larry. I mean, I agree with Peter regarding the CCDA because there is so much movement in that direction and I agree we ought to be leveraging that. The thing I was thinking about is, I went through this conversion seven or eight years ago, from a legacy system with fifteen years of data and I moved everything, so basically everything in the list you saw before, I moved. But the one thing that's not listed anywhere here is the audit trails. I didn't move, obviously, the audit trails from the old system to the new one, but I did have to save it in a separate file so that if I were to get sued down the road, I needed to be able to show who saw what when.

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

Yup.

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

And so that's an important export.

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

Right, right. And with claims and other administrative data, what's your thought on that Larry?

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

Well we did...actually, I guess what we prob...I think what we did was we actually did a cut off where we stopped billing...I think we kept our old billing system live for another year, I believe...

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

Right, just to...

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

...just so we could run it down and started from scratch on the new one.

**Steven J. Stack, MD – Chairman - American Medical Association**

Hey Larry, this is Steve Stack. I'm curious, when you said...I can understand how audit trails play into legal process, but if you transfer from one vendor to another and cease to maintain the previous and go to a new one, does that really represent a major risk? I mean, is it not sufficient to say that data was not carried over in the transfer from one system to another and it's just not there, through no fault of your own?

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

Well I guess I'd have to ask the lawyers on the phone to see whether I made the right decision, but what we felt was that we could store it in a database, that it was something that was reasonable to be able to do, and that's what we did. We have an Excel...I don't know, I don't know what kind of database we put it in, but there's basically in a database they've got who saw what when.

**Steven J. Stack, MD – Chairman - American Medical Association**

Well, let me put in a context, so I'm not specifically trying to query the attorneys input into that as much as there are key and essential elements we hope we can carry over in a migration from one to another. And I guess a bunch of this metadata does not rank up there as one of those key and essential elements.

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

Yeah, I don't...I mean I can say...this is Deven. I can't say definitively...I just can't imagine that you need to port all that stuff over, as long as you don't destroy it and that you still maintain it for as long as your recordkeeping requirements require you to maintain it. If it's not useful to the ongoing use of the system, I don't think you need to port it over.

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

Well that's the thing...there's the difference between porting it over, which we didn't do for the audit trails, but what we did do is at least maintain it because we shut off our old system, it's I shut the switch off, it's gone, and so...but we wanted to be able to maintain that data.

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

I think you're probably fine.

**Steven J. Stack, MD – Chairman – American Medical Association**

Great, and the only reason I was ma...that was just one good representative example I think to the broader point I was making, which is, the current standard probably conveys a fair amount of data, and that's good. And the more data we need to provide the clinical care over time that we can preserve when we do a migration from one vendor to another is essential. But there's volumes of data in there and not all of it is equally important when it comes to maintaining your practice and providing the care to the patients.

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

Right.

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

Right.

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

So...

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

And I think it's...

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

...go ahead Larry.

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

...so as I said, I moved 15 years of data and we turned on our new system and its...I would not have been able to predict in advance what was important for any particular patient. I find myself, because I have a powerful electronic health record, I can go search and see the last time a patient talked to me about their back pain, and I can see that it was 15 years ago. And I can see my note and see what I did at the time and what worked and what didn't work, so I don't have to make the same mistake again and...or that they've been on this medication 12 years ago or that...I mean, it's almost impossible to predict what's been valuable. But geez, when I pull up 20 years of weights or cholesterol results, it really is impressive to the patients and I think it adds a much more meaningful education to them and is more motivating when they see, oh my God, look what's been happening. And so it's really hard to know what's the most important.

**Steven J. Stack, MD – Chairman – American Medical Association**

Right. Thank you.

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

Right.

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

So, it seems like there's a lot still left on the table outside of the common meaningful use data set, right, I mean when you dive down into this.

**M**

Oh yeah.

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

So, that seems to be one question is what...maybe is one way of framing it that thinking about the content that could fit within the CCDA constructs. But as I was listening to the audit conversation, it strikes me, do we want...is there something to say with something like that as well, which is about it's not necessarily about machine to machine portability, but it's about making sure that the EHR that you're departing from has export capability. So that it's...I don't know, I'll make up words, electronic format that's at least human readable, so you're not going to upload it into your new EHR but you do want to be able to have access to it should you choose to retain that.

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

Well actually, that was the last comment on the slide, a few commenters felt more work was needed to ensure EHRs are able to import this data...

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

Right.

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

...and that is important, because no one wants to retype it in after you export it.

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

Yeah.

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

I mean some is easier to import than other, I mean, some are just plain old factual, non-debatable information, this is the note that was done by this consultant on that date.

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

Right.

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

Load it right up. This is an immunization, they got it, load it right in there. The things that do need to discuss, problem lists, the allergies, meds, those are some things that often people need to decide whether or not they want to bring them in, but medication fills, it happened, load em up, for the most part.

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

Right. But this doesn't contain...this doesn't have most of what you said, right, the common meaningful use data set, if I'm looking at this, encounter diagnoses, immunizations, cognitive functional status, referral and discharge instructions, that's all it's got.

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

Yeah...low level importance.

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

So, within the CCDA construct, would this suggest that if we were to monkey around with this, does that suggest the need for a data portability template within the CCDA architecture, for example? Is that the way that would get implemented.

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

Well just, I mean that is a possibility...

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

I would think so.

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

...yeah, I mean because the templates are about to grow dramatically in the consolidated CDA following a successful ballot in September, because we're...our transfer of care summary is going to be in there and that document includes all the elements for care planning. And it's basically compared to the CCD, which had 175 data elements, we're almost up to 500 data elements specified in our templates. So it will be more robust, whether it still meets the needs, it's hard to say, but it certainly will...

**Steven J. Stack, MD – Chairman – American Medical Association**

I'd even suggest that it's probably going to be a series of templates, you wouldn't want an entire patient's record in a single document.

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

Correct. Right.

**Steven J. Stack, MD – Chairman – American Medical Association**

So we need templates for ambulatory visits versus inpatient admissions, etcetera.

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

But at least the template library to choose from will be larger.

**Steven J. Stack, MD – Chairman – American Medical Association**

Right.

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

Sounds like another S&I Framework Workgroup.

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

I mean, it seems like...it seems to me like the right answer is not for us to try to list every possible type of data element that one would want for data portability, right?

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Do people agree with that?

**Steven J. Stack, MD – Chairman – American Medical Association**

Yes, this is Steve. I would have to agree with you, I think for the policy level, we want to make absolutely clear the expectation that vendors cooperate with, facilitate, enable not impede, do so reasonably and without malice and all those sorts of things. We want to make sure that they make it possible to make these transitions when necessary. But to spell out each individual thing starts to get us to prescribing levels of a detail, like Larry just said, that we really can't reasonably anticipate and can't put a one size fits all for all different settings or needs.

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

Right. Right. But...so then on the other hand though, are there categories that we might want to sort of call out that at least supplement the common meaningful use data set that we have here, or are we just down the slippery slope then, once we start doing that?

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

I mean I...think the fact, as Peter was alluding to, is the fact that if vendors are starting to build the ability to export and import CDA based documents to match the consolidated CDA library, then they've done most of the hard work. Except right now it's at a transition of care, so basically is a snapshot in time of where they're at, and maybe what we need to do also as Peter was alluding, is that they need to have different parameters for generating these, such as historical encounters. So basically, from...go back from any historical encounter and generate one of the consolidated CDA documents representing that encounter.

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

That's a really good point.

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

Peter, how does that sound? Does that...if you were told you need to be able to generate a CCD, let's say or some consolidated CDA document for all your encounters over a period of time or of a certain type?

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

I think that that's probably the direction we should be talking about. It isn't a capability I think that most EHRs have today, but it's pretty close to some things that we do, as you may know.

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

Right.

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

Well it's good to recommend things once in a while that EHR vendors aren't doing today.

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Right.

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

Keeps you on your toes Peter.

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

Well exactly, but it's in line with the things that we are doing, so it's not a completely new kind of technology.

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

Yup. Yeah, yeah, that's great. So I think that seems like it's a great recommendation. So there may be a couple of things here related to...so let me just back up and describe where at least I hear that we may be headed. Which is, the CCDA construct still makes sense as a construct, in part because that's where everything is headed and a lot of work is going there, and that seems like it will suffice for what we want it to accomplish. In terms of the content, we're in this transition stage where that content is being enriched dramatically and so, and this is where I'm going to wave my hand a little bit and see if there's still a gap there. And so it may be that where this ends up landing with transition of care and other kinds of enrichment of the content of CCDA that that might have...it might capture almost all the information that one would want. And then the only other thing that we would have to talk about is the usability for data portability for...with respect to issues like the triggering and historical data. And there may be some other kind of functional sorts of things about the scope of what the CCDA covers, both in terms of time and content that we need to say something about.

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

Right that the CCDA document needs to represent a particular type of encounter over a particular period of time.

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

Yup. Does that make sense? So, I mean is it enough to say or is that a little bit too weak to say that the direction of the content, as you were just describing Larry, is probably going to be enough to cover the needs for data portability. I mean, as much as we can tell right now without getting overly specific where we think we would probably be wrong anyway.

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

I mean I would think until...I mean if we use Stage 4 when S&I has had time to meet and create a new set of document templates to...document types for the consolidated CDA to specifically be for this purpose, I think the ones that are in there may have to be good enough for now.

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

Right. Okay. All right, well maybe we can try to...offline can try to write that down in a couple of slides, and I'm sure some questions will come up as we do that, so I may reach out to a few of you to get greater clarity on what you were saying. But that might be a good...it might be at a good place here for sort of stopping, trying to say, why don't we collect those thoughts, because it seems to me like there's enough structure there to start to form the basis of a set of slides. And then we can use that as the launching point for our next call, which I think is in a week, if I'm not mistaken.

**Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology**

Yes, it's on the 29<sup>th</sup> from 2:30 to 4 Eastern.

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

Okay. Does that make sense to everyone? If not and you have some other great thoughts about this that you haven't spoken up about, please, now is your opportunity. Okay. So why don't we go with that approach then. So I think that's it in terms of the agenda for this call, so we can give everyone back like 20 minutes of their day. We have to go to the public comment, but let me pause and see if there are any other questions, concerns or comments from anyone in the workgroup. No, okay. Well, let me say thank you first off to all of you for joining the call and for your great contributions, as always. And why don't I turn it over now to Michelle for the public comment.

**Public Comment**

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Operator, can you please open the lines for public comment?

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

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

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

Okay. Great. Well thank you everyone, we'll talk soon.

**Michelle Consolazio – Interim Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.