

**HIT Policy Committee
Information Exchange Workgroup
Transcript
September 9, 2013**

Presentation

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

Good morning everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Information Exchange Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as the meeting is being transcribed and recorded. I'll now take roll. Micky Tripathi?

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

Here.

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

Deven McGraw?

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

Here.

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

Amy Zimmerman? Arien Malec? Chris Tashjian? He's on mute. Cris Ross? Dave Goetz? Jeff Donnell? Jonah Frolich? Peter DeVault? Larry Garber? Steven Stack? Ted Kremer? 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.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

And John Feikema's here.

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

Thanks John. And with that, we'll pass it over to you Micky. We have a small group today, but we should probably announce that we are fortunate enough to have a new co-chair on the IE Workgroup, which I don't know if you want to announce that Micky.

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

As long as – to do it – no, I am delighted to announce that Deven McGraw has agreed to co-chair the IE Workgroup. So, Deven's been a longstanding member and I think was a co-chair at one time before –

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

Yeah, no, we did co-chair this workgroup way back in its early days.

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

Right, right. We call those the glory days and now we – the glory days. So welcome Deven and thank you very much.

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

No, than you Micky. I'm glad to be able to take a more active role and I'm also pleased, as someone who sits on the Policy Committee, that I'll be able to help translate these recommendations at the Policy Committee level and I hope to be helpful in that regard. This is a really important workgroup and again, I'm excited to be working more actively with all of you.

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

Great. Thanks. So I should also just say I know we have a small number on today. I did hear from a number of people who wanted to join and can't, in particular Steven Stack and Larry Garber are two other physicians who are very active participants sent their regrets over the weekend and they had conflicts that they couldn't get out of. So, they are still very engaged in what we're doing here and they just couldn't make this meeting.

So today we're going to review the Policy Committee meeting that just passed, I guess it wasn't the one that just passed, maybe the one just before, where we presented our recommendations on data portability. And as we'll describe, there was a lot of spirited conversation related to the recommendation and they asked us to come back and think about a few more issues and then bring it back to them, as we'll discuss in greater detail. And that led to our reaching out to a couple of different folks to try to get their perspective on this question as well. And so we have folks from the Standards & Interoperability Framework team as well as EHRA, who are going to provide us with some more background information, that I think will be very informative for us, as we rethink some of the comments that we got from the Policy Committee. So, why don't we go to the next slide?

Oh, sorry, I'm actually looking at my local version and – okay. And let's see, next slide please. So we did present the recommendations that we had made to the Policy Committee and there wasn't any – there wasn't consensus across the Policy Committee to move the recommendation forward. And they asked us to revisit a couple of the issues there. And so one of the questions was, regarding whether this could be resolved – whether this problem, because there's a problem, there were some questions about data portability and whether it belongs in the IE Workgroup. And there were some other problems about the approach regarding sort of the CCDA construct that we had laid out as being an approach to solve some of the data portability questions that were there before us. And part of the discussion was whether there was a more universal way of addressing this and whether there were some other initiatives that were thinking about that.

And so I think that's part of the conversation that we want to have. There were also some questions regarding whether meaningful use is the appropriate lever to be using to try to attack the data portability problem. And, there's – so obviously questions of scope around the table here that we want to kind of think through a little bit. I think an important piece of background information is that 2014 certification does have some language in it related to certification requirements for data portability. So, whatever we do, we would need to sort of reconcile it back with what's already in there, which we were kind of taking that as a foundational sort of stepping-stone. And saying, let's take that to the next level, in terms of being able to allow a user to build on the construct that's already in the certification process, and perhaps have a little bit more control over some of the parameters of what would come out of it, based on what was already in the 2014 edition certification.

But the conversation, I think, started to look at things in a broader manner and in effect, kind of asked us to think about it in a broader manner. So, I think that's what we want to do here. There were – the fact that we had included administrative data in that, again, sort of also touched on the question of germaneness with respect to meaningful use and whether that was appropriate or even possible. There was also a suggestion that I think came in the Policy Committee and further conversation within the ONC team, of whether we want to consider splitting the concepts of the use cases of data portability for the purpose of enabling a patient to be able to switch a provider and have the confidence that their relevant medical information is transferring as seamlessly as possible from one provider to the next. And the use case of a provider who is switching his or her system and being able to transfer the records from one system to another. We had kind of put those together, just saying that they're different use cases, but that a similar approach could address both of those. There is a suggestion, as I said, that perhaps they're different enough that we may want to consider them separately. So I think that's one of the things that we're going to want to think about as we go forward here.

So, next slide please. So today, as I said, we're going to be hearing from folks from the S&I Framework as well as EHRA. And then in terms of our immediate work plan, we're going to use this meeting as well as the next two to get into some deeper discussion about the data portability question and then see what kind of consensus we can get out of that with an eye toward the October 2nd HIT Policy Committee meeting. And whatever sort of updated or revised recommendations we might have for that workgroup. So, before we dive into the presentations from the S&I Framework team, let me pause and see if anyone has any questions or, for anyone who was on the Policy Committee call or the meeting, would love to hear any other context that you might add to this.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah Micky, this is John Feikema. One thought that was interesting for me, or helped sort of describe how the Policy Committee was framing some of the thoughts around this was as they separated the patient perspective from the provider perspective, they introduced, or someone introduced two new words. One meaning when a provider wants to move systems, they call that migration and when a patient wants to switch practices and as a result needs to switch from one EHR to another, the thought was that might be transportability or data portability. It sort of helped me frame differently how those two issues might be addressed.

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

Hmm, yeah, yeah. I think that's – yeah, that's interesting, I'm glad you picked up on those. And I guess, yeah, a question for us is, are they different in nature and if they are, then I think it would be very important that we use different terms for them, that would help us keep our thoughts together. So, thank you for that. And maybe now you're going to tell us that they are indeed different and that's why we should use different terms.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

No, actually I wasn't going there, but –

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

Oh, you weren't – just kidding. So maybe one goal that we should set is if we think they're the same, we should use the same term, if we think that they're different, we should use different terms.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah the reason I brought it up more than anything was just it seemed to be where the heads of at least a couple of people on the Policy Committee were, and once a decision is reached about whether they're the same or not, I agree, making sure that that language is used carefully may help the situation in general.

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

Yeah. I think you do – this is Deven. I think you do need to treat them differently because the ability of a patient to get information from a provider record so that the patient can have that sent directly to a new provider, is really a HIPAA issue, covered under the patient access rules. Doctors have 30 days to be able to do this, they can take up to 60 if they need additional time, such as if there's data that's housed off-site that they need to be able to get a hold of. And it doesn't mean that having some consistent portability standards wouldn't ease that transition significantly, it would, but it's very different than the ability of a healthcare provider to say to its contractor business associate, I'm not working with you anymore. I'm going to be using a different vendor and I need on day one to be able to immediately transition to using this new system, or something close to that.

I realize that that's setting a very high bar. But there the relationship, at least from a legal standpoint, I don't know if this is the way that it works in practice, is that the vendors work for the docs and to the extent that they are going to sever that business relationship, the provider nevertheless has a legal obligation to have an operational record at all times. It's just – they're very different circumstances, notwithstanding that sort of common portability standard helps address both.

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

Collaborative

Right. So yeah, and that may be the case and I think as we dive into this, we can sort of test whether those parameters that I think you appropriately draw Deven, do in fact – or would in fact translate into a different way of thinking about a certification require – because I think I'd also raise the good point, just as a reminder to the workgroup, I mean what we were focused on was the – just the 2016 edition certification requirements, not a meaningful use requirement. So this is really just to have the technology capable of doing the things we're recommending, leaving aside the question of whether – what timelines will be placed on that in the event that it had to happen and so forth.

And just to draw it in very general – I know this is generalizing grossly, but I think the approach that we were taking was just think of an EHR as being a database, so it's really simply a large database and you need the ability to get data out of it. I think kind of the approach that we were taking was to say, all right, so what's the vehicle for getting the data out. Well, we're already building a whole bunch of stuff around use cases that are enabled by the CCDA construct, so okay, so those are the vehicle that we say; let's build on – follow on those vehicles. And what the 2014 edition – certification edition says is use the meaningful use dataset for that, and that's kind of all it says. I may be mis-characterizing that, so someone can correct me on that. But I think that's roughly what that said and in a way, what we were doing is to say, okay, well if that's the vehicle that's already been set up, what we want to be able to do is allow the provider to set the parameters of when you would start – when the CCDAs would start or what would define what – which CCDAs we're talking about. Or what's the content of those.

So, some of the things that we're essentially posing is, you need to be able to define when – the start date, I want it from five years ago to the present and an end date. Or be able to say, I want it for this patient or for these types of encounters, which I think the idea was that that would satisfy the patient-centric view, because you're saying I want it just for this patient over the time period. Or it would satisfy what Feik was referring to as a migration view, which would be no, I need it for all data over the last ten years, but only these encounters because – encounters don't matter for migration, or whatever. That was kind of a general construct, but you may indeed be right, Deven, that we look at it and realize, those are really two different things because of the HIPAA requirements on one and the vendor contract requirements on the other. So, with that as background, does it make sense to turn to the S&I Framework presentation?

M

Yeah, I think so.

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

Sounds good to me.

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

Okay. Great.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

So, we can go to the next slide. Just to frame out a little bit what we're – what I hope to spend a little bit of time on today, talk about some of the, I use the word history here, even though the initiative is only a couple of months old, the thoughts have been rattling around for some time. So we'll spend a little bit of time talking about that, try to frame what we're – why we think this is important, outline some of the at least initial thoughts on scope and where we hope to land. So that's all I want to cover today, certainly leave enough time for Q&A and discussion here, I think that would be helpful for me.

So, on the next slide I included this slide, not that I need to cover it, but I don't know that I'm allowed to give an S&I presentation without including at least this overview slide once during the talk. Just to – I'm sure everyone here has seen this 100 times, but just sort of the normal flow of things, and we're in that very first box. If you look at the next slide basically the same information, but talking about the different steps in the process. We finished with our charter, meaning we've reviewed the overall introduction with the community and are now spending our time walking through user stories and trying to make sure that we all agree on what a common set of objectives are.

In the next slide, just to sort of frame things, Blue Button, as I'm sure everybody knows, is really a patient focused initiative and this data access framework is really focused on the provider, helping them to get access – better access to their own data or better access to the data for one of their patients at a known location. So we would call that a targeted query, not HIE-like where they want to scan the universe of possible locations for data, but the patient – they know that the patient has seen a care provider at a certain location, they've had a conversation with that care provider, they have the necessary permissions from the patient. And so what we're really focused here on is the technical infrastructure, not the policy stuff, and in fact, we're hoping that parallel efforts around some of the policy issues related to targeted access do continue in parallel, and we'll modify our approach as needed to deal with those.

One of the major things that – or, beliefs that we have is that the current industry standards really aren't modular enough to allow us to do some of the things we want to do. Queries and searches within a practice really aren't governed by standards at all and queries between two practices while there are certainly things like NwHIN Connect that allow a very specific set of use cases to work, they're very specific. And one of the things we did differently in this when we started is reflected even in the naming of it, I mean, we aren't calling it the Data Access Initiative, we're talking about a framework. Because we believe that there is a set of different issues that a provider will be facing, where the appropriate answer to those issues could be a population-based set of data instead of just a patient-based set of data. And it could be granular – much more granular than you would get returned by a CCDA.

So for example, even though there are some nice IHE specs that talk about this, they don't really let you – they don't give you the flexibility that you need to have all those different kinds of queries that you might want. So in many respects what we're looking at here is a matrix where there's a variety of different use cases, each of which will, in all likelihood, require a different set of technology to solve it. And our job during this initial user story timeframe is to pick a couple of specific user stories and then come up with the standards that allow us to do that. And I'll get into this in a little bit more detail as we dig into the slides.

On the next slide, the second bullet point there is, I think, one of the keys. And one of the things that Doug is doing a really good job of keeping us focused on is that we want to be able to have a framework where you can substitute where divided the elements of a query into multiple layers. Probably not altogether unlike in a communication or networking framework, the way you break-out different levels of a stack, and we want to be able to substitute in Direct versus SOAP versus some other REST-based transport. We want to be able to substitute in different authorization frameworks as needed. We want to be able to substitute in different payload-based requirements, all dependent on what the query is. So that modular and substitutability is one of the things that is driving us as we're looking at standards and maybe – probably will be the – one of the more challenging aspects of the overall objective.

We're really looking to help a couple of different communities in the process here, not just the physician who wants to be able to get additional information about a set of encounters that happened at a different place in the targeted query example. But we're hoping to provide more data liquidity within the practice so that third party vendors who have – that are coming out of ONCs innovation community have the ability to do complex or specialized searches, queries and then manipulate the data that they get back. Things that the EHR isn't capable of doing and perhaps specialized enough that the EHR vendor has no interest in doing that, and as a result, the data is kind of landlocked there and they aren't able to do anything with it. While EHR vendors in general offer some sort of local search capability, the challenge is and the feedback we're getting from the innovation community is, they can't build a separate interface for every single EHR and as result, the cost to them of building a scalable – horizontally scalable solution is just incredible. So any ability for us to create a standard way of allowing data to be extracted from an EHR would be welcome.

On the next slide –

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

John, before you go –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yes.

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

Sorry John, before we go to the next slide, can we just back up one second?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah. Sure.

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

So does that mean that the Data Access Framework is not – I'm looking at the second bullet, does that mean that you're not looking at the patient use case, a patient wants to move from one provider to the next?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

That hasn't been a driving use case of ours. It is – you are correct; it has not been a driving use case of ours. However, if, as I go through some of the standard or some of the user stories that we have, the technology – or the approach that we're taking could be very, very easily extended to allow us to do – to extract not just a part of a patient's record, but the patient's entire record. So, it's extensible to do that and some of the guidance we may get is that that is, in fact, a very important use case that we ought to pursue. It wasn't a part of our original founding impetus, if you will.

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

Okay. And so right now that doesn't have a home within the entire S&I Framework as far as you know, or does it live – are the Blue Button folks thinking about that at all or –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

No, well, that's really – to the extent that the patient drives the process, Blue Button could do it. To the extent that – and then it happens out of band from the provider's perspective in many respects, right, it's something that they drive. To the extent that the patient wants the provider to assist in that, the closest thing happening in S&I for data portability, at least from the patient perspective side, would be the Data Access Framework. And we had some conversations just last week, as I've been digging into the data portability issue and reflecting on the past meetings of this group and the Policy Committee where it had been looking at extending one of our use cases so that it would address or could address this patient portability issue.

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

Okay. And then one other question, you had said – I think you said you used the term the innovation community. You said, feedback you're getting from the innovation community, who is that?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

There is a Department or an area inside ONC, who has been recruiting and working with a lot of third party vendors who are interested in – you know, I think some of it came out from some of the early work that Todd Park did around data port – data liquidity. And he attracted I'm sure a bunch of folks who were interested in that Rebecca, I'm blanking on her last name because it changed recently. Kory, do you remember Rebecca's last name?

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

I think its Mitchell.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah, is leading up this effort and has a community of third party vendors that are very interested in providing tools – care-based tools using data that would be in an EHR for follow up, to reduce readmissions, to help with care planning, just as a couple of examples.

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

Yup, okay. Got it. Thanks.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

So in fact, if you – on the next slide, there are a couple of examples of the bullets – the sub-bullets in the second bullet sort of talk about some of those kinds of use cases that are coming to us out of this innovation community. How do we follow up with medication adherence? How do we enable social workers or other caregivers access to the data that is appropriate for them as a part of the patient care episode? And the first one is really intended for a primary care doc who wants to understand what his patient population looks like and how do I dig in and do a better job of providing care to this cohort within my practice? And it will include this use case – this local data access will include an extraction capability based – in the manifest itself in an API. And assuming we write that properly, one could easily build patient portability tools using that API.

So on the next slide we are, largely as a result of some of the work that you guys have been doing over the last couple of weeks, we are looking at it – how feasible is it for us to extend this so that we could address the patient portability issue directly in scope. And it's – these discussions are having me look at the relative priorities of that use case versus others and we're increasing them as a result. We are a consensus-based process, so I'm hoping as we run this through the community, we get a high level of interest in those use cases, but suffice it to say, there will likely be some leading of the witness, if you will, so that we do get there. And the other sub-bullets here are some of the other use cases that have come up from the community as we've talked through some of these issues. One of our community members, interestingly, is Hans Buitendijk, who's going to be on the call later, from EHRA, and he's a member of this initiative.

I talked about – in the next slide I talked a little bit about one of the things that's driving us to try to modularize this and this is a small subset of that larger matrix that I alluded to earlier. But it's intended to highlight the fact that one of the reasons why we're calling this a framework, because we think that there's a myriad of potential user stories or use cases, some of which will require patient-level data, some which would require population-level data as a response. And then within that, either document-based, can I get a CCDa back, or do I want just the more cellular or granular data within that. And we think that this will require different sets of standards based on which cell in this matrix that you live in. And that's what's really driving us to approach this –

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

Collaborative

Um hmm, good.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

– like we do in the next slide where we're trying to take these different layers – different components of what we think constitute a query or constitute data access and break them up into these different layers and allow different standards in each of those layers and allow those to be substituted in and out, depending on what your user story is. In some respects, what we're hoping is – one of the metaphors we used perhaps is almost like a deli where you don't want to have to publish every single possible combination of cheeses and meats and veggies and breads in order to decide what sandwiches are available. We want people to be able to build their own by deciding at each layer of that stack is appropriate for their query. So rather than assuming that there's only one solution for everything, or five solutions, we're trying to build a framework here that's modular enough that depending on what your use case is, you can pick the right components as you go. It's, I think, that conceptually it's a very interesting challenge. I think it remains to be seen whether – how far we're going to be able to get on that.

If you look at the next slide, this one's really supposed to give you at least a flavor of some of the existing or initial candidate standards that are in play at each of these layers. And these are the ones that we'll be working through as we pick a specific user story, we'll then look at this list and, I'm sure, bring in others to pick the standards that make the most sense for what we're doing. I think as a result, we hope that this initiative is more than just the first two or three user stories. We're hoping that this becomes sort of the strategic framework for data access within ONC, so that it will have legs, we think, for years to come as we focus on specific cells in that matrix or specific layers in this stack. I think I'll pause here for a second and see if there are any questions around this or any feedback or thoughts from folks.

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

Well this is Deven. John, I have some questions generally, but they're not necessarily on the content of your slides, but more towards the substance of what we might be aiming at, so –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Sure –

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

– I can hold off until the appropriate time.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Sure, I've only got three more slides, so we can move on to the next – as a – this isn't really intended to represent the universe of all queries, because we realize that there are other complex situations that are broader than this. But this at least gives an opportunity to envelop those that are part of the ONC thought process to date. The one on the far right has been around for quite a while, the original Query Health, the distributed query philosophy. And as we looked at that, and as we thought about that as candidates for MU3, one of the things we realized was that it was a pretty long pot for an awful lot of organizations.

There are certainly advanced HIEs or advanced health departments that have embraced it and have working pilots or production systems in the field, but for the average health system, it was a fairly daunting thing. In part because participating in a distributed query network required that at first you be able to expose your existing – I mean policy issues aside and governance issues aside, it still required that you be able to publish or make available all of the data within your network as a part of this. Or all the relevant data in your network, to be a part of that network, and that's where the vast majority of our folks spent a lot of their time and were getting tripped up. And we said, maybe we ought to step back and maybe we tried to solve the big problem first, maybe we should try to solve letting people have access to their own data. And then letting people have access to data with whom they don't need to worry about an automated consent management issue, they can handle that manually, the way they do today, if we provide those tools to them, we might go along ways toward making that third column easier at the end of the day anyway. So that's really what we've done is we've stepped back and we've said, we're going to focus on those two on the left side of it for at least the next year or 18 months, that will be really where we focus.

So the last slide with real content on it is just to outline that we're really focused Phase 1 on local data access, which would/could encompass the patient paradigm for data portability. Phase 2 is going to be focused on the targeted access; I list here what's in scope. We have – and then we have the bullet at the very bottom there to talk about, our side step. We recognize that there are a lot of policy issues here around consent management and patient ID for example. We're going to deal with those at least in this early phase manually, assuming that people exchange data today, they have a manual process for consent and for authorization and for patient ID management.

And we're going to leverage those existing things and then work with the FACA groups and Office of Policy and Planning, as those issues and frameworks for those issues mature in our thought process, we'll then build those back in and leverage those as needed, so that the targeted access is more scalable. So you can see there what is in scope, we're hoping to come up with implementation guides and pilots and folks who take advantage of this for both local data access as well as targeted access. And we will be building APIs to allow this – allow folks to have programmatic access to these.

And then the very last slide is just where we meet, all the information that's stored online, if this group is interested, can certainly go out there and get that or I can make available whatever other artifacts are of interest or appropriate.

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

Great, thanks, this was really helpful and a lot of information. So, Deven, it sounded like you had some questions, do you want to start?

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

Well, so what I'm – yeah, thank you Micky. What I'm trying to sort of piece – to sort of figure out in my non-technical brain is whether there's any distinction either from a policy or a standards perspective, from the sort of types of sort of query-based access that you're taking on with this data access framework part of the S&I Initiative. Versus the sort of issue of I'm switching vendors and all my data needs to be ported from one vendor to another or a patient is switching providers and a substantial amount of relevant data needs to sort of be sent and be consumed and operable in a new system. What, if anything, are really the differences? Are we talking about sort shades of interoperability or is it all still relevant to the same sort of basic interoperability question?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah –

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

Yeah, because this access framework incredibly important for data exchange generally and the ability to sort of find your patient's records for treatment or other relevant purposes, either within an organization or across organizations. But, we were sort of taking on this issue from a – if nothing else, a different volume perspective.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah. You know, on the one hand it seems like if you can extract via an API all of the relevant information about a patient, you should be able to do that “n” times, I mean, write a script and if I've got a hundred patients, I just do it a hundred times. I mean conceptually it seems like you should be able to do that. However, my gut says that there's a whole host of additional problems that you run into if you think that that's a way to – or if you try to operationalize that and do that for a practice, certainly for a large institutional system, it's just my gut and my past tell me that there's a whole bunch of unforeseen consequences of thinking that that would be an adequate way to allow a practice migration issue.

I think that many of the standards that we uncover and work with and use could be some of the same standards that are – that could be leveraged to do that. But I think that it would require a very focused intent to do just that. In other words, I don't think it is – I don't think one can assume that gee, if we can extract it for one, then all we need to do is put a wrapper around that and do it “n” times and all of a sudden we're done. I think that stepping back and looking at the migration issue would require an effort in and of itself focused to make sure that there aren't a bunch of side issues that weren't thought of in the process. Certainly some of the – well, that's just what my gut says. I think the other thing is there are an awful lot of systems out there where the financial or administrative data and clinical data are not housed in the same system –

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

Right.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

– so just being able to pull the clinical data out doesn't mean that we've solved the issue for the financial, and I'm not sure we've got good tools or standards, certainly none that we're looking at within the data access framework would be X12 relevant or any of the administrative constructs that are necessary to protect that data.

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

Thank you, very helpful.

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

Collaborative So John, this is Micky. Given where – so, just a couple of things. So you're really focused on the data access framework, as you pointed out, and it's really mostly focused on enabling query types of use cases, whether they're local or cross-entity or what have you. And then I think, if I understood your answer to Deven correctly, that doesn't – it's – there are probably going to be some issues in assuming that one could extrapolate from isolated queries to saying that, okay, now all I need to do is do a hundred thousand of those and I've solved my migration problem. So where does that – that sounds like the data portability issue doesn't live anywhere right now in the S&I Framework and what's your sense of what we'll be able to accomplish in the way of standards and an approach that one could hope to be able to put into the 2016 edition certification.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah, that's the \$64,000 question, or non-inflation adjusted. It's a very good question and one that in light of these conversations of late, I'm spending a fair amount of my time trying to dig into, and I'm still early in that process. I'm hoping to learn as much from this group as – I mean, I'm certainly interested in sharing everything that we're doing with this group, but I think that your next set of speakers will be informative for me, as much as anything. Because I don't know that we've got answers to those questions yet, but they are front of mind.

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

Collaborative

Right, because I mean it's going to be challenging enough just getting to the basic query set of standards for something that we feel confident enough to be able to put into the next edition certification, let alone this new thing that we're adding, or that we may be adding. That may or may not be a natural extrapolation of that –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Right.

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

Collaborative

– if I'm understanding you correctly. I mean, there'd be investigation needed to even find out where are the common threads in that. It may be that the guardrail sort of common roots in that type of approach – or in the portability approach.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

I agree. Yeah, I was kind of hoping that Larry was going to be on the call this morning because on one of your last meetings, he talked about having migrated from one system to another. I think he alluded that it was six, seven, eight years ago and he didn't ever want to do it again, but it would be – I'd love to hear more from him on how hard that was. How much would standards have helped? How did they do it? And one of the things I think – I think Farzad asked on the August Policy call is, how are people doing this today? I mean, there are – people are picking new vendors and moving today, how do they do it? How hard is it? It would be interesting to do sort of a scan of folks to see if there are some learning's, even from folks who have done it recently, people in the last 18 months who've switched vendors, it would be very interesting to have a bunch of those come in and give horror stories or success stories, as it were.

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

Collaborative

Right. Yeah. I think Hans and John might be able to give us a little bit of perspective on that –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yup.

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

– but I think the overall answer is it doesn't happen very often because it doesn't – because it's hard to figure out how to do it well, I think that's the reality of it.

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yeah, I think – yeah. And I think that – high switching – I think Farzad again said that high switching costs aren't necessarily signs of vibrancy in a market, so –

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

Okay. Well, this has been really informative. Are there other questions or comments on this? Because otherwise – I don't know if Hans and John have been able to join.

Hans Buitendijk, MSc, FHL - Vice-chair EHRA SI Workgroup - Siemens Healthcare

This is Hans I'm on.

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

Oh, great. So, any other thoughts on the stand – on the S&I Framework conversation, otherwise, we can turn it over to Hans. No, okay. Great, well thanks again John, this is really helpful. So why don't we move ahead to the presentation from EHRA and –

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Sure, thanks very much. By the way, I said thanks, but I was staring at a red mute button, so, thanks for the opportunity.

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

Understand. Great.

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

Thanks John.

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

So, Hans, if you're on, we'll turn it over to you and want to start by thanking you for putting together the materials and for helping us learn more about data portability.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

Thank you very much, and really appreciate to have an opportunity to talk. And I think we're going to be looking forward to this conversation. I heard a little bit about the previous topic and one of the elements there is that it's an ongoing effort to try to figure out how to access data and how to, in this case, port data. So I think we're looking at this as the start of a conversation, not necessarily that we have all the answers today by no stretch. So, if you can go to the next slide. We have put a couple of slides together, want to quickly introduce who is on the call today from an EHRA perspective and then dive into it.

Both John Lauer and myself are on the call today and hopefully we are able to provide some more insight and perspective on what portability may be how to support data migrations in different use cases. Unfortunately Charles – , our Chair of the Standards & Interoperability Workgroup could not make it, so he passed the baton to me, and with John's help, we'll get through this.

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

Hans, before you move from the slide, you've got to tell us how to pronounce your last name so we can – it later.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare
It's Buitendijk.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative
Great. Thanks.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

And I can give at some point in time a hint as to how to figure that thing out in English. So if you can go to the next slide. Based on the question that we received from Kory Mertz in preparation of this, there are two use cases that we were asked to have a look at and that was just before the Labor Day weekend.

And as it happened to be right after Labor Day weekend, we have a standing meeting of that workgroup and I took the opportunity to check it out and have a discussion about it. So the discussion and the findings or some of the information that we're providing is really based on a couple of days' worth of good email exchange, good conversation on the conference call. But we all agree is that, that's just the start of a conversation, we are looking forward to we refine whatever we said today, look at it further and hopefully as we move forward, perhaps create a white paper or some other follow up information on it to get more information from our membership as well.

So we did look at these two, where we are looking at portability as providers change EHRs, not only one to one but in this environment we have to also consider many to one, that they may have many systems, particularly in larger settings, many systems that they may converge and change to another EHR. So it could be many to many, many to one, one to one, a couple of different configurations that are in play there. And then we also looked at the portability as patients change primary care providers.

We tried to identify what are some of the methods that are being used and that people raised as, this is what we use here or there or some combination thereof. We looked at the current MU2 capabilities and had some thoughts on how they support these two use cases, and some thoughts on how to move forward. One of the general conclusions that we had so far is that there are similarities across the two use cases, but one size, one solution does not fit all. There are some variations between them that require a different perspective on how one can most easily migrate the data. If you can move to the next slide.

So looking at the second one first actually, patients changing primary care provider, the common methods that we see out there are clearly paper copies, electronic copies as PDF, as they are available. It may just be specific elements, certain test results, certain information and only as of late that we start to see CCD and CCDA clinical summary documents being either pushed, pulled, flash drive through a PHR, but that's really at the infancy, that's really just starting. The most common methods when a patient moves are paper copies and perhaps some electronic copies. Part of that is driven by the intended use, what are we trying to achieve between where the patient is moving from to where the patient is going, consistency of data, and compatibility of data. So, it's really going to be interesting to see how, in that environment, the electronic versions are going to settle in and be used, as the patient moves from one provider to the next. But I think it's really fair to say that we are at the infancy of this, not a lot of experience yet in the electronic space as the patient moves.

But, when you go to the next slide, we do think that as we are moving forward, that – and considering the MU2 capabilities that are currently about to be deployed more widely, that the CCDA approach is quite suitable for this kind of a migration. It has a substantial data set, there are a variety of document types that are available that could be utilized. There is ongoing work to improve the data set that the CCDA can cover. So we believe that the CCDA is quite suited for this purpose, where you can have the opportunity of one CCDA per encounter, per visit. And as they are made available, as they become available anyway as a result of summary of the visit being generated, that when the patient decides to move on to another care provider, those CCDAs can be pulled and moved forward, in a variety of different mechanisms. Be it with the patient on a flash drive, be it through direct, be it through an IHE, be it through PHR, a number of different transport mechanisms that can then be used.

There will be some challenges with pre-MU2 data in that prior to that, vocabulary standards, data content may not be as consistent, may have old vocabulary, may not have been generated into CCDAs at the time, because it wasn't there, etcetera. So we do anticipate that older data will still have some challenges and will – may have to rely on some older techniques. But as we progress and more information becomes available electronically, that that challenge will be less over time. So that's looking at it from a portability perspective, patient moves.

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

Can I, Hans, can I just stop you for a second?

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare
Yes.

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

Feik, are you still on?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

Yes I am.

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

Just wanted, I know you have to leave; I just wanted to ask you a quick question. Just, just on this slide, the – Hans' sense that the CCDA is a good approach, this was exactly the – sort of the foundation for our recommendation, the IE Workgroup's recommendation. I just wanted to get your sense of, how does this kind of mesh with the way you're thinking about all of this at the S&I Framework?

John Feikema – Coordinator, Standards & Interoperability Framework – Office of the National Coordinator

It is a – it is one of the leading candidates that we think is appropriate, I listened with interest at the last one where there's a question of whether the MU2 data set is inclusive enough. But, I think it's certainly the right place to start, the question is, do we need to take it further, and that's an open issue at this point.

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

Right. Okay. And the reason I – did someone have something else, sorry. As I said, the reason I wanted to highlight this was I think this was a point that we got considerable pushback on at the Policy Committee, but from what I'm understanding, both of you have the sense that this is sort of a good construct to proceed forward with.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

Yes, and it's – if you look at the data set, the clinical summary that currently MU2 is looking for, that EHRs are able to provide, that the providers are intended to be making available to their patients, is that you're building up a library of solid summaries. And clearly there is opportunity for improvements, nobody's going to argue that, but it's a good starting point and it lends itself very well where the patient is moving. So the PCP still has their own – the EHR that they have, the PCP that they're moving to still has the EHR that they have, that's not changing from their perspective, it's the patient who's moving. So that's a natural – a reasonable, natural approach to take. When we get into the next one, I think, is where we're going to identify some challenges and differences that CCDA is not necessarily the only vehicle to use, and at times might not be most suited for it.

So let's move on to the next and check that environment. So portability as providers change EHR, where we have many to many, one to many, one to one, whatever the configurations might be, here it changes a bit. Some of the methods that are being used, frequently you would see is that the old system is capped, but for read-only purposes only. So access is being maintained that way, be it for old financial data, be it for administrative, be it for clinical data, there are a variety of different reasons for that. But keep the old system in play for a number – for some amount of time that the usefulness, the life of that data has started to disappear and then start to gradually remove that system. Don't use the old system for actual operational use, read-only only. That's one method.

Another one is that data is being converted using tailored file formats, various conversion tools, HL7 Version 2 standards for example. If you want to get all the results in from the past across all the patients, use the HL7 Version 2 results messages and run them right into the new system. Use the ADT messages to run a number of the administrative data in and then augment it or instead of, specific files. And it all depends, at that point in time, on exactly what's the purpose of the data, and we'll come back to that. What are we trying to preserve? What's the quality? What's moving forward, etcetera? And it depends on the size of the system, the kind of environments that come in play, but we'll come back to that as well.

Starting to see, similar as with the patients, starting to see CCD and CCDA documents, but again, very much at the starting point of that and trying to figure out where does it fit, where does it not. But also generating/exporting reports, there are many reports that can be generated already, make those available, hold on to them electronically, otherwise scans and include them for read-only purposes. And then there are classes of data that are manually re-entered for a number of different reasons, that the effort to create conversion tools, the availability of standards, it's either not there or it's just not worth the amount of time and effort for the unique scenarios that a manual re-entry is most appropriate to do. So effectively what you will see is a mix of these. You will see typically, depending on the systems involved, a combination of manual re-entry, old systems being kept read-only, file conversions, etcetera, etcetera and with some emergence of CCD and CCDA documents.

If you go to the next slide, a little bit of parameters that drive that. The care setting, if you're in a single hospital, large enterprise, single practice and anything in between, the configuration, the infrastructure that is in place, the number of systems that are in place, which systems are the master systems versus just follow suit, in terms of the data. Where does the ADT occur, etcetera, all drive what kind of data is being converted, how much needs to be converted and what the complexities are. So if you're dealing with a one to one EHR conversion, it's a completely different answer, potentially, as that you have to convert multiple systems. So that's a key driver as to what's feasible, what's available, etcetera. A second driver is that the ability to map the old data to new data structures. Is it appropriate, reliable to take old data in the way it was collected at the time and map it to the most current vocabulary? Do we add interpretation to that data that actually was not known at the time, so you're changing the meaning of the data? So how much can I actually change from a conversion perspective and how much do I need to hold on to it as is, and how can I do that? So there will be clearly some consideration of, is it older, pre-meaningful use kind of data, or is it more data that has been collected under standards identified in Meaningful Use Stage 1, 2 and upcoming 3, etcetera.

So, the other part is, is it operational data? It's one thing if we talk about what's the core clinical data set around a patient. But if I need to also convert, at some point in time, orders that are in progress, care plans that are in progress, and I need to operationally have continuity of the use of the system. There's data that CCDA or other standards would not necessarily cover, but they are essential to maintain the operational flow of the system before and after so that we can progress with that. So that's another set of considerations that will determine which of those methods are appropriate or not. If you then go to the next slide.

Is that there really is a lot based on what's the intended use? What kind of data is there and what is it supposed to be used for? Where can we get it from? What's the most reliable source of it? It might exist in two, three, five different systems, what's the source that you want to use as the source of truth? Do I need to combine information, because some data is – the core data might be the same, but the additional data in order to run those systems is not the same, and how much do I need to preserve? How much can I not preserve because the new system just works differently, configuration data would be a good example in that? So this slide is by no means trying to be complete, but it started to get some better perspective on, we have in the old EHR a number of different data, likely more data to fill in there.

And we have different purposes as to when we're moving the data, what it's to be used for, and that combination is going to really determine what techniques, what methods, what standards are already in play that can be used, have to be used or not appropriate to be used. Or, at times, have an orientation that says, well, if I'm going to use this method, then I'm going to actually redo the same thing three, four times over and I now need to reconcile the data from a couple of different sources back into one source on the target system. So that's where the complexities start to come in.

When you then go to the next slide, some considerations of applicability of MU2 standards, and clearly CCDA does support a subset of relevant data. At the same point in time though is that you look at a setting of – a hospital setting, and you take a discharge summary, it certainly will not have all the data from that inpatient stay, inside the document. Whereas if you are looking at an individual provider visit, outpatient visit, the probability that the CCDA contains all, if not almost all, is much higher. But, when I'm in a hospital setting or an enterprise setting, I do have a need to get a lot of the other information across as well. So, how do I do that? All the data may not fit in, same consideration as in the other use cases, but even more so with the volumes of data that are there.

So, if we were to say, well, let's use the CCDA for that, we may have to relax some of the standards to accommodate some of that older, unstructured data, older vocabularies, etcetera, because they don't quite fit. They fit today, but they might not fit in the past. And document orientation for large data volumes, when I not just need to get the core clinical data along with the patient, but I need to get the system moving from one operational state to a new operational state, using a document orientation is not as efficient all the times either. As at that point in time I have a list of all the results that may end up in multiple documents, I have a list of patients that may have, over time, different names and different addresses and what not, it's an in between step that is not always that useful.

So it depends on what you're trying to do. One size does not fit all. If I'm looking at some of the data that I only want to carry forward for view only, perhaps, and there is good value to a document orientation. If I am trying to get large volumes that I then can operationally reuse in the new EHR, perhaps other methods are more efficient like running in a V2 results batch of data. So that's where the challenges are going to come in, when you're going to port from one EHR or a configuration of HIT that makes up the EHR to a new configuration of EHR and trying to ensure that the right data comes across. So, one size does not fit all in this scenario, a refined or enhanced CCDA can satisfy some, but not likely everything in the way that this is being described. So we believe that other methods, beyond what is currently made available through and prescribed through Meaningful Use Stage 2, other methods are still required. And they are highly dependent on the configurations and the data involved.

So with that, going to the last slide, is that the use cases of a patient moving from one provider to the next one, primary care provider to the next is substantially different than a provider changing their EHR environment and within the settings that that happens, there are different levels of complexities that start to crop up. So the CCDA is well suited for patient's porting their clinical data to another PCP, but certainly would not cover the full suite of data migration needs that are out there. So other methods are essential as well and consequently we urge that as we think about this and move forward on this, and try to drive some best practices around this, we really urge, at least initially and through the discussion, not to immediately jump onto expanded certification requirements. But how can we identify a variety of tools, approaches, best practices that might be more process-focused rather than specific tools, that can help ease that process. And depending on the complexity of the environment, certain tools may suit very well; other ones will require a substantial amount of tailoring and consideration as part of the deployment to make sure that works.

And that's why I think you will see, and are seeing is that migrations are not always that easy, because there is the desire between having a lot of data move across, some of the data is not necessarily always needed for the ongoing operations. Other ones are needed for legal medical purpose – medical record purposes, etcetera, so there's a wide variety of data requirements that will drive what is and what's not needed to move from one EHR to the next. So that's where we would like to stop at this point in time and certainly we started a good conversation within EHRA, there was a lot of interest in this topic. And there's also a sense that we have a lot more to talk about, and that hopefully that this conversation will help with making further progress in clarifying what are reasonable approaches to support portability. Clearly there is support for that in the industry, to make this work smoother. At the same point in time, we need to recognize that there are quite substantial complexities in there to make it easy within the current tools that we have available and that currently are in play.

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

Thank you. That was very helpful and very informative. I've got one question to start. So, is there an argument for saying, well, let's not let the perfect be the enemy of good. And so, the CCDA approach can accomplish much – a lot it sounds like, for the patient use case and some subset, whether it's a substantial subset or a small subset of the problem for the provider use case and therefore it might make sense to go forward with that? Is there an argument for that do you think or – we also don't want the good to be the enabler of the bad, right, so?

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

The initial reaction, as we are seeing it emerge, that that kind of a perspective on the patient moving primary care provider sounds like a reasonable approach. Because the CCDA does provide a good set of information and an evolving set of information as document types are further evolving as well, sections are evolving, etcetera, etcetera, that provides a reasonable path for that. So I think that such a perspective would be reasonable in that use case. When we're looking at the EHR, moving from one EHR configuration to another EHR configuration, it's not to say that the CCDA could not play a role in that. At the same point in time, if one sets the expectations that the CCDA would provide a substantial amount of portability in that space, given the complexities, that would be a challenge and I would be very careful with that. And that's where I think that's where that approach would – we should be very careful taking that approach so that we have more of a conversation about, okay, it's not just the clinical data that needs to come across if I change EHRs, I have other data that needs to move along as well. And if I need to move that data, is it always the most efficient way to have – to utilize both techniques, use one, use the other, use some combination of that, and that may very well, as we currently see, be driven by what's actually there in that particular configuration. Because the capabilities of one EHR and the other are not the same, what they need is not the same, so there is data beyond that core clinical data set that needs to be taken into account together, not separately, but together, and that makes it challenging.

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

Micky, this is Amy and I joined late, I only caught the end of the previous presentation, but I have a question. And maybe the answer is the same, but related to looking at cost, so if a provider is switching from one EHR to another, obviously it's a fairly big – there's a fairly big cost in terms of time, money and resources. From the migration point of view, is it more cost effective to sort of keep the system you have as read-only, except for some critical information start aggregating in the new system? Like where does the cost factors fit in – into this, in terms of the different approaches that you've been talking about.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

I could not, based on the discussions; however, I could not be able to give a cost perspective on whether it's substantially more or less. It depends more on the individual scenarios, what kind of data are you looking at? Is the data that you want to use, can you truly just use it for view-only purposes or do I need to have it in the context of my – in the next EHR, my clinical decision support, my planning, my context that I need to have. So, the answer will vary, there is certain data that lends itself to view-only, and the older it gets, the more – that it is more suitable for certain data as well. And there's data that I need to move on, in order to take advantage of as part of the new capabilities, the decision support that is in play, etcetera, etcetera. So, I don't think there is a straightforward, today at least; there is no straightforward answer on cost benefit, whether it's always better to keep a view-only or whether it's never better to keep a view-only.

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

Thank you.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

And John, do you want to add any other thoughts to that? John Lauer – he was on the phone as well.

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

Yeah I know he was supposed to join, I'm not sure if he ever did.

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

Yeah.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

No, I think he did, but he might have –

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

Oh he did, okay.

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

– on mute. So I – this is Deven McGraw, I have an additional question. You mentioned a couple of sort of other potential data migration rules. How widely available are these and how well do they work?

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

Um, it depends. If you say that I need to migrate data and let's say I need to get a series of results, lab results otherwise across from one environment to another using the V2 batch transactions are available, people use them. You have a core data set that there's good agreement around and there are some additional data that systems have different variations in how they manage it, so there's some mapping challenges there. But if the tools – or if the data suits those kind of transactions, those are available in terms of the standards and then the rest around that. If you're starting to talk about there are no standards available per se that I could express the data in, then you very quickly are going to be dealing with anything from somebody puts out a – in the data that they can put out. And then somebody needs to create, for that combination of systems, a mapping to import that data into their environment that could be then a mix of just files, spreadsheets, you name it, there's all kinds of different variations out there. They are then specific to the individual systems that they bring to the table as part of the migration process. So, there's a wide variety out there.

John A. Lauer – Member EHRA SI Workgroup – QuadraMed

Hi, this is John. My line had been placed on mute through the conference service, but I'm on now, can you hear me?

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

Yes.

John A. Lauer – Member EHRA SI Workgroup – QuadraMed

Okay, I was trying to talk a minute ago. I'm going to let people respond to what Hans just said and then I have a couple of comments.

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

No I think that was helpful information. Why don't you go ahead, yeah?

John A. Lauer – Member EHRA SI Workgroup – QuadraMed

Okay. We do, as Hans said earlier, truly appreciate the opportunity to look at this issue and to explore it with you and provide our thoughts on this. This is an issue which my company is working on a major conversion right now and I've been in conversation with our customers on this topic and a number of the things that we have been talking about have been issues that we have explored, just within the last week. So, it's a very important issue and one that's very foremost in, at least in my recent experience.

The – it really is important to understand what the customer is trying to accomplish with the data that they have. The customer has to become involved, and I say customer because I'm a vendor, but the user of the EHR has to become involved in helping to map out the data that they know they have in their old EHR and what they want that for. And lo and behold it turns out that they want it for multiple purposes, one is it's going to go into the new EHR, but it may also be preserved into a new data warehouse that they're creating. It may go into other systems. So that was why we put that matrix together to begin to come up with a way to characterize the source data and the columns identify possible uses.

There are two uses, which are pretty demanding and rather unforgiving and one of those is clinical decision support. When people start depending upon the EHR to help them with clinical decisions, you better have all the right information there, coded properly and understandable. So that's one that's not very forgiving. The other one is the legal medical record and whether the old data is considered to be the legal medical record or not is key to what you're going to do with that going forward. So if it's the legal medical record, and they intend to re-create a legal medical record somewhere else, then that drives issues about what data you need and how it might be exported. So we found that the matrix approach was helpful to think about it, and we are not done. As Hans said, we're going to continue our work on this and we look forward to staying in touch with you and maintaining some ongoing relationship here in terms of what we discover and the questions and the discoveries that you have.

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

This is Kory, one quick question. Hans, when you were talking you were kind of talking about the difference between clinical settings. Did you guys, in your conversations, did it come up that maybe a different or like is it less complicated in the ambulatory setting versus the hospital settings? Was that part of the conversation or would you say people thought it was kind of similar levels of complexity across those different settings like that?

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

We did not specifically say that it's more or less complicated between an ambulatory setting and a hospital or an enterprise setting, but clearly there are indications that it is involving potentially many more systems and purposes. I think as John also indicated, what's the purpose of the next EHR that is using it and what data do I need to make that happen, whether it is a single system small practice or whether I have a large configuration, essentially it's the same question that you have. But the volume of data, the number of systems of data, therefore the potential sources of what data is the driver, is going to be less complex the more that you are in a single system, ambulatory, single provider setting. And again, goes rapidly up the scale when you go to the larger practice, multiple system, hospital, enterprise level where the complexity goes up rapidly.

John A. Lauer – Member EHRA SI Workgroup – QuadraMed

I might add to that that the – in the EHR in the acute care setting, the EHR typically is managing a lot of workflow and that's the process issue that we listed on one of our bullet points. In the ambulatory setting, that's not to say that there is not – there are not processes, but they are far fewer and probably far less complex than are the processes in the acute care setting. And it's that process orientation that really drives the conversions to be somewhat – considerably different.

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

Great. Thank you.

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

So Micky, I think –

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

Yes.

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

– aren't we until 12:30, so we're actually –

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

Yes, we are.

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

So we have a couple of other calls to take some of this – take this into consideration and re-deliberate, but we probably should leave time for public comment.

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

Yup. Yeah. Sorry, I was fumbling around with my mute and all the other wonderful things that my phone allows, except getting back on the call.

Hans Buitendijk, MSc, FHL – Vice-chair, EHRA SI Workgroup – Siemens Healthcare

If I may make one last comment is that we do plan within the EHRA to continue this discussion. We started with this as a result of the question; we do plan to continue that. And as John also indicated, we would be happy and looking forward to further conversation around it and we're going to explore as to how we can capture the input and the information that we receive into some form of document, whatever shape it takes, to help with this discussion as well.

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

Okay. Great. Yeah, that would be great and it sounds like John's already working on this with a customer, so he can just tell us what worked.

John A. Lauer – Member EHRA SI Workgroup – QuadraMed

Yes, exactly. And what we have is one conversion is one conversion.

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

Right. Okay, great. Well, thank you very much and so we got a ton of great information today I think and a lot of valuable perspective. And we have two calls coming up that we can start to digest this and see where to take it from there. So why don't we turn it over to – back to you Michelle for the public comment.

Public Comment

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

Operator, can you please open the lines?

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 public comments at this time.

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

Thank you.

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

Okay, great. Thank you everyone.

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

Thanks.