

### **Data portability (included in preamble of as request for comment)**

The concept of completely moving to another software system is ideally a good idea, but considering the complexity of the different types of information in the EHR (listed next paragraph), the information that yet do not have standards for exchange and that have not yet been addressed in any of ONC's requirements, moving all of the data would be a huge challenge, and of course extremely expensive. An analogy would be moving data from a Unix system to Windows or Apple. While some general documents could be moved, the database, middleware, and applications do not generally support this type of transfer process.

Areas not yet covered are numerous, including ICU workflows, flow charts, interfaced equipment (ventilators, IV pumps, anesthesia machines, medication robots, etc.) , clinical decision support rules, non-standard coded terminology (data models, and data elements), codified physician notes, codified nursing documentation, codified therapist information (respiratory , dietary, physical, and occupational therapy), transfers, ambulance and life-flight records, Operating room records, Operating case carts and supplies, etc. In addition, there are personal health records; how are these to be handled and transferred? Also genetic and family history information. Then there is the billing (ICD9,CPT) and scheduling information, billing is more straight-forward, but scheduling and encounter history has non-standardized components in the process.

1. Is EHR technology capable of electronically providing a sufficient amount of a patient's health history using summary of care records formatted according to the Consolidated CDA for the scenario described above? Probably not, especially for complex , long hospital stays, and probably not for complex patients w/ chronic disease
2. Is all of the data in a provider's EHR; #1 necessary to migrate over to EHR and #2 in the event the provider wants to switch? We recognize that medical record retention laws affect the provider's overall approach in terms of a full archived data set, but our question seeks to determine whether the loss of some data would be tolerable and if so, which data? Again, for simple visits to the EP and hospital, it would suffice, but for some specialist EPs, chronic patients, and long hospitals stays, especially intensive care, probably not.
3. Considering the standards we have adopted and propose for adoption in this rule, we request comment on what additional standards and guidance would be necessary to meet these market needs for data portability, including the portability of administrative data such as Medicare and Medicaid eligibility and claims. Flow charts, ancillary care (therapists) notes, dietary, ventilator settings, and a host of other detailed clinical information would be necessary.
4. Additionally, we are interested in comments related to an incremental approach where a specific set of patient data could be used as a foundation to improve data portability for the situation described above as well as other situations. Most clinicians would be happy just getting summary documents transferred, even if in pdf form. Next steps include transferring standard CDA summary documentation with the

data that is codified to standards, that could be consumed by the new EHR.

5. Does the concept of a capability to batch export a single patient's records (or a provider's entire patient population) pose unintended consequences from a security perspective? What factors should be considered to mitigate any potential abuse of this capability, if it existed? Certainly. Batch export of multiple patient records for a provider's entire population list is risky. Just a list of patient DOB, name, SSN, and/or medicare/Medicaid information could be catastrophic from a medical-legal/privacy perspective. Not to mention facilitating fraud and abuse if a list of patients were exported, with all of their data to the wrong hands.