

# Information Exchange Workgroup Transcript July 12, 2012

## Presentation

### Operator

Ms. Robertson, all lines are bridged.

### MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup. This is a public call, and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I'll now take roll. Micky Tripathi?

### Micky Tripathi – Massachusetts eHealth Collaborative

Here.

### MacKenzie Robertson – Office of the National Coordinator

Thanks Micky. Hunt Blair? Tim Cromwell? Jeff Donnell?

### Jeff Donnell – No More Clipboards

Here.

### MacKenzie Robertson – Office of the National Coordinator

Thanks Jeff. Peter DeVault for Judy Faulkner.

### Peter DeVault – EPIC Systems Corporation – Director of Interoperability

Here.

### MacKenzie Robertson – Office of the National Coordinator

Thanks Peter. Seth Foldy? Jonah Frohlich? Larry Garber? Dave Goetz? James Golden? Jessica Kahn? Charles Kennedy? Ted Kramer? Arien Malec? Deven McGraw? Stephanie Reel? Cris Ross? Steve Stack?

### Steven Stack – American Medical Association

Here.

### MacKenzie Robertson – Office of the National Coordinator

Thanks Steve. Chris Tashjian? Chris, I believe you're on the line; you might be on mute.

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

Right.

### MacKenzie Robertson – Office of the National Coordinator

Jon Teichrow? Amy Zimmerman? And are there any staff on the line?

### Michelle Nelson- Office of the National Coordinator

Michelle Nelson, ONC.

### MacKenzie Robertson – Office of the National Coordinator

Thanks Michelle.

**Tari Owi – Office of the National Coordinator**

This is Tari from ONC.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Tari.

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

This is Kory Mertz.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Kory.

**Emma Potter – Office of the National Coordinator**

Emma Potter, ONC.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks Emma. Okay Micky, I'll turn it over to you.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, great. Thank you. So good afternoon everyone, thanks so much for joining, I know this is a hard time of year with vacations and all that, so I really appreciate everyone's joining. Today we're going to talk a little bit more about the Stage 3 recommendation process that the IE workgroup is now going to be engaged in. And, want to really move forward, build on the conversation that we had last time, which was sort of just about general principles, to now see if we can start to chunk out some of what we're going to need to do into some coherent sets of activities and get some sub-workgroups lined up to start to get our arms around what might be a useful set of recommendations for the Policy Committee meetings that are coming up in August and then again in October. So, let me ask if we can dive right into the presentation. We've only got an hour, so want to be able to give enough time to it. So, okay, first slide.

And the first slide is actually wrong, but let's go today...so the goals for today, these are the same goals for today that we had from the last meeting, so you may think that we're setting a very low bar by having the same goals...so, in my haste putting this together, I forgot to update the goals for today. But the goals for today are actually as I described. What we want to be able to do is sort of take the conversation that we had from the last meeting, where I think what we discussed was are there some high level objectives that we want to think about as we think about moving to Stage 3. And as I recall, and please correct me because my memory is faulty with all these different meetings, I think where we ended up from the last meeting was basically saying we certainly want to consolidate the gains that Stage 1 and Stage 2 have...well, Stage 2 recommendations, will presumably sort of instantiate in this entire process and in the market.

But, thinking ahead to Stage 3, there were two specific things I think we talked about that, from an interoperability perspective, that we want to figure out how to bake those into a set of objectives that will move them forward. One is, to categorize just generally query types of transactions. So, the classic use case of the ED, ED use case, trying to get information from other settings for a patient that has come in in an unsolicited way, into that care setting. So, I think that was one set of things that we talked about. And the other, I think was about trying to see if we could move forward in any way on administrative transactions, where I think prior auth was one that we talked about, and there may have been some others as well. That's my bare bones recollection of the last meeting. Let me just pause here and see if others have anything to add on that discussion, any further thoughts or any other thoughts on where we might take this.

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

That sounded great to me. This is Peter.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Great. So, I think what we want to do today is think about how do we now take that to the next step of saying, how do we break this up into perhaps a specific set of transaction types or kind of functions...interoperability functions that we want to perform. How would those then translate into a set of objectives, and I want to propose that some goals for the day, that we get our arms around sort of a framework for thinking about that, and we've proposed. But, this is really for workgroup discussion and input, a way of separating those things into three categories that would then be led by sub-workgroup teams that could then, over the next month or so, spend a bunch of time in a focused way on those particular categories, much like we did with the governance workgroup. So, next slide please. And next slide.

So, first just the timelines. I think we...this is the same timeline as last time. August is going to be all the workgroups, not just ours, identifying preliminary Stage 3 recommendations. September, there is the expectation that the CMS and ONC final rules will be released and so...and in October, beginning of October I think is the HIT Policy Committee, so we want to have the finalized recommendations by then. So, our rough roadmap here is to develop some preliminary recommendations and in August HIT Policy Committee present those preliminary recommendations. In September, we expect the final rules to come out so we may need to recalibrate, depending on what the Stage 2 final rule says, and then spend the rest of September sort of refining and honing our recommendations to develop them as final recommendations for the Policy Committee. And I think the idea is that the Policy Committee in November would issue a request for comment based on the Policy Committee level recommendations from all of the workgroups and by the end of the calendar year, get public comment back on that first round of recommendations. Next slide please.

So for this workgroup, you may recall from the last meeting that sort of the work plan that we had originally envisioned was that on July 31st, we would get from the Meaningful Use Workgroup some draft recommendations from their continuity of care I think is what the subgroup is called, workgroup that would help us. And as you can imagine, there was a lot of information exchanged, pieces in that that would help us just as a starting place. As the strike-through there indicates, we didn't get that. So, we're kind of on our own here right now, which is good news and bad news. Not that they aren't doing any work, but they're still at a pretty high level, so, none of those thoughts I don't think have fully crystalized yet, so they're not really in a shape for us to kind of take them and run with them.

So, we've kind of recast this a little bit to say, well today what we want to do is think about sort of the framework that we're going to use, form some sub-workgroups. And then by the next meeting, which is two weeks away, have those sub-workgroups share with the entire workgroup what their preliminary thoughts and recommendations are, so that we can sort develop those for the August 1 HIT Policy Committee meeting. And again, that's all very preliminary, so, I think we'll just get done what we can get done, and then spend, as I said before, August and then September working on honing those and finalizing those with the Stage 2 final rule coming in the middle there, for us to sort of calibrate on. So, sound like a plan?

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

Sounds good.

**M**

Works for me.

**M**

Yup.

## **Micky Tripathi – Massachusetts eHealth Collaborative**

Great. Next slide please. So let's just dive into the meat of this. So, here's my sense and, again this is all open for discussion, is that we've got three key questions in general as a workgroup and as sub-groups that we want to answer. One is which HIE functions should be promoted in Stage 3? So to the extent that there are already sort of a set of things that we call interoperability or information exchange function, which ones of those should we really be thinking about, sort of propelling forward. And some of those were going to have their own momentum, push, direct, all of that is going to have its own momentum. Lab results delivery, all that, has its own momentum in Stage 1, Stage 2; so those carry forward and so part of that is the carrying forward, perhaps to a higher level of things that have already been established. But then some of these things are going to be about what are the new functions perhaps that we want to be pushing forward. And we have a slide or two that can help tee up that conversation.

And then the second is having decided that then, how do we translate those into concrete meaningful use objectives, because, at the end of the day, that's how all of this will sort of enter the meaningful use program. And then finally, as we think about that, what criteria do we use to determine sort of the breadth and depth of each objective. So, as all of you are now expert in, you can sort of say that something should be a part of a meaningful use objective, but then you get into the nitty gritty of, is it 2% or 10% or 50%. How do we think about, not that we have to necessarily come up right now with that level of granularity, but, we want to be giving some thought to, how do we think about the criteria for what...how we should be doing that and in particular. Are there sort of goals from a care perspective or from sort of national goal or national strategy perspective that we want to be thinking about as sort of context and criteria and filtering as well, as we think about translating those functions into objectives. And we have sort of a slide from the Meaningful Use Workgroup that they're using for that and we could take that and shape it any way we want. So, let me go to the next slide.

So what I've done is just throw down on a slide, and this is again, open for all of your changing and I see the numbering got all screwed up, so don't pay attention to the numbers. But, I've tried to take and just put at one path, some categorization of, when we think about HIE functions, what are we talking about here and is there some way of grouping them. So, we've put into high-level groups a set of things under quality and efficiency, a set of things under care coordination and patient and family engagement and a set of things around public health and then e-Prescribing fell in that one as well. But again, we can group these any way we want. And so the specific ones, as you can see in each of those. One has a set of things related to decision support, which, on the face of it, isn't really about interoperability necessarily. But is there a thought about having decision support that is able to consume information from other places and to able to then take that information and then use it to drive decision support within EHR, for example, might be an example of how you start to think about that having an interoperability component to it.

And claims/clinical could be...claims/clinical integration could be a piece of that, or not. Again, this is just...the idea here is just cast the net as widely as possible in a brainstorming kind of way, and then we can sharpen this as much as we want. Quality reporting had similar dimension. As we know, eMeasures are in some stage of development but...and then on the other side, and I put eReporting, but QRDA I think has now been sort of tabled and voted on by HL7, so, that's a little bit further along perhaps. And then the administrative simplification; there's a whole bunch of stuff there that meaningful use hasn't really addressed at all. So, that's a little bit more open. Transitions of care, I think that's fairly obvious what that is, the data exchange with patients, communicating with patients, all under that heading. And then finally, public health, which is saying, how do we move to the next level of public health, being able to query, for example, for immunization registries, being able to get information back, for example. There was always the talk early on of EHRs being able to consume public health alerts, for example, and so, just put that on there. And then, ePrescribing, obviously has a couple of dimensions.

So, some of the questions that are...first off, does this list look roughly right, if not, let's sort of tweak it as much as we need to. Second is, is there an overlay regarding interoperability with mobile communication devices that somehow needs to be incorporated here. And I'm not, I'm not saying that this should be, but, to the extent that mobile is a whole other sort of mode and mechanism, is that related to this or not. And then finally, portability, meaning data portability across EHR systems for example to take care of the case when a provider moves from one EHR system to another. That has come up as an issue, both in ONC internal staff, has come up as issues in other places and one question is, does that fit into the Information Exchange Workgroup domain in any way. So let me pause here and get all of your reactions to this.

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

Micky, this is Amy, and I just want to let you know I joined the call late, but I just joined.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh great, thanks Amy.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Micky, this is Cris Ross; I joined late as well.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh, terrific. Thanks.

**Lawrence Garber – Reliant Medical Group**

Okay, while we're confessing, this is Larry; I joined late, too.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh great, terrific. Thanks everyone for joining, we've got a good turnout. Cris, got a better turnout than for the Standards meeting this morning.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Uh oh. It's a throw-down now.

(laughter)

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well on that note, this is Cris. I think you've got three oceans to boil here, so I'm reluctant to ask anything more, but there's maybe two pieces that sort of stand out at first glance. One is, anything around...actually, three. One is, anything around devices and anything we might want to do about that stake, devices to either patient implantable or portable or home monitoring or any of that stuff.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

The second would be, things related to accountable care more generally, and I totally understand how some of these sub-pieces like claims/clinical integration would completely support the notion of accountable care and risk management and all the rest. But maybe perhaps something a little bit more explicit around population management or group management or assignment of care, coordination of care, perhaps more explicitly. I don't know how to frame that better.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yup, yup.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And then the last one would be potentially, communicating with patients might be a little bit too limiting compared to patient-driven communication or patient-initiated or patient self-management, those kinds of things, just to broaden that slightly. That's my comment.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yup, those are great comments.

**Steven Stack – American Medical Association**

Hi Micky, this is Steve Stack, and I didn't just miss the first few minutes, I've been gone for 4-6 weeks, so I'm at a disadvantage here, but I think that the three areas you outlined are quality and efficiency, care coordination and public health are consistent with the paradigm we've been using, so, I'm fine with that. Again, I'm not sure we need to add much to it, although I think that the previous speaker's comments about those other facets are interesting. I do have the...as we look and work through the month now and August, I do have the question or concern for you or anyone else on the group, about, I find it a little bit challenging not knowing what the Stage 2 final step is, and really not having very robust data back on how Stage 1 is going yet, to envision really fully what is pragmatic or reasonable or attainable for Stage 3. And so, I'll admit a little bit of challenge on that part.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. On that, and I think that's a great point, we did, at the last meeting, have some data from the REC program to sort of help inform, in kind of a crude way, because, that's only one slice of the provider community at large, and also the data is sort of limited in certain ways. So, we did sort of try to get at what does that suggest about where we are on Stage 1. I take your point on Stage 2, although I do think that we kind of...we can have a pretty good guess at 97% of what's going to be in Stage 2, I think. I welcome other people's comments on that.

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

Yeah, this is Chris Tashjian. I also agree that we have a pretty good Stage 2, but also, Stage 3 I think, it's worthwhile at least taking a stab at it. We've got plenty of time to change it if we need to, but I think taking a stab at it...

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

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

And I...go ahead.

**Micky Tripathi – Massachusetts eHealth Collaborative**

I was just going to say, I think there is this iterative loop which is...I think we'll get to when we look at how do we think about the criteria here of not wanting to get too far ahead of what's possible, either from a technology perspective, a standards perspective, a process perspective. I know...I think the Meaningful Use Workgroup, I think there was a call that John Halamka from the Standards Committee had sort of offered to weigh in on, at least his sense on what's mature and what's not and we could certainly ask him to sort of...because once we start defining some of these things a little bit better, get his read, and others as well, not that he's the only voice in this, but, that can sort of help us get out of that iterative loop anyway.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Micky, this is Cris, Cris Ross. Actually, that work on standards with respect to that level of trend for maturity and so on, is actually something that the NwHIN Power Team has been doing, as part of the Standards Committee, and their meeting later today. So, letting you know that that work is underway. So I get a three-fer today.

**Micky Tripathi – Massachusetts eHealth Collaborative**

All right. We're going to have you then help us on that.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

All right, turn to Dixie, she's the chair and is doing a fantastic job.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Lawrence Garber – Reliant Medical Group**

Micky, this is Larry. On your bullets 5 and 6, data exchange with patients and communication with patients, I'd probably merge those two together. I mean, it's bidirectional information exchange with patients and there's so much overlap that it's probably not worth making them separate. The other thing is that in the first number 4, the transitions of care, there's also some other information buried in there such as consent processes, authorization, potentially even master patient indices that would be part of that.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, that's a really good point. Both good points. MPI and I guess provider directory...

**Lawrence Garber – Reliant Medical Group**

Right...PKI

**Micky Tripathi – Massachusetts eHealth Collaborative**

What...let me just go back to one thing that Cris had said about devices. I don't know, I guess I would have put that in the category of things that are patient generated data, but I guess we just don't want to lose that that's another dimension of patient generated data. I didn't have my mind about patient generated data, but that is another type of patient generated data.

**M**

Totally agree.

**Michelle Nelson- Office of the National Coordinator**

Micky, this is Michelle. That's how the Meaningful Use Workgroup has looked at it.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

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

And this is Amy; I was going to say the same thing. I was also going to say, I think it was in our last call on the Meaningful Use Workgroup we had some discussion about that and just sort of about the home devices and uploading to the HER. And really, if we go down...if anyone goes down that road, really thinking about not overwhelming an EHR with data, so what is important and what isn't. If someone's checking their blood sugar three times a day, I'm not sure the EHR really wants to know three times a day what someone's blood sugar is versus a trigger, or a pattern or a trend that then triggers something. So, I know we had some discussion about that as well, in terms of just capacity of the EHR and what's useful, helpful and meaningful, versus what would be more than necessary and not necessarily helpful.

**M**

Right. Yup. I think it makes sense.

**Micky Tripathi – Massachusetts eHealth Collaborative**

How about this question of mobile communication devices, cell phones, smart phones, does that...is that sort of a different dimension than any of this, or does it have its own sort of side.

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

Micky, this is...

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

Micky, this Amy. I came on late so I didn't hear your intro on that and I don't want you to go back over it, but is that...was the thinking that the EHR has to be able to support interoperability with mobile devices? Like what's the impact on the EHR perspective on that in terms of what you would want in the EHR.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, I mean, I'm basically just asking the question. It's just that it's another medium, it's another...but it's increasing...as we know, it's sort of increasingly powerful and we can expect that it's going to be used more and more and certainly all EHR vendors have their mobile applications as well. Now I don't know that it should be thought of any different than any other type of medium, but...I think Peter was going to say something.

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

Yeah, yeah, and actually, it was along the lines of what you're just describing Micky. I actually don't think it's a medium at all, but kind of an endpoint, and that we should probably try to keep our meaningful use requirements independent of endpoint. So, regardless of the way somebody accesses either the EHR or the PHR or the secure messaging portal or whatever it might be.

**Micky Tripathi – Massachusetts eHealth Collaborative**

That makes sense to me; does that make sense to everyone?

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

This is Amy and yes, because that's kind of where I was going. I was trying to understand how it fit in to the EHR side of things.

**M**

Yup, definitely.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So, let me ask this question now about portability, because that's a whole can of worms. We did try to deal with this at the certification, I think it was the...well, I forget which workgroup it is, the Larry Wolf workgroup.

**Michelle Nelson- Office of the National Coordinator**

Certification or adoption.

**Micky Tripathi – Massachusetts eHealth Collaborative**

I do think it's the certification...yeah, the certification adoption, right. And I remember it was a really complex...it was one of those things that seems seemingly easy, and then all of a sudden you dive into it and realize that it's really very difficult and the thought...now I remember. At the time, there was a thought about should anything be in Stage 2 with regards to portability and the sub-workgroup at the time came back and said, no way. And, kicked it down to maybe in Stage 3. Well, now here we are in maybe in Stage 3, so, I've got two questions. One, is this even an IE Workgroup issue at all, should we even think about this as being information exchange or is it really just a part of, certification and move it over to another workgroup, or, have the other workgroup take primary responsibility, which I think they are anyway. And then the second is, to the extent if we think that there is any role there for us, how do we think that we would approach it.

**Lawrence Garber – Reliant Medical Group**

This is Larry.

**M**

Go ahead Larry.

**Lawrence Garber – Reliant Medical Group**

Okay, thanks. So I have, in both the number 4 and 5 transitions of care and data exchange with patients, also hidden underneath there is really the data sets that you're going to be using, whether it's the CCD or some...or the other CDA based documents or something else. There is sort of a misunderstanding that there's a certain document type with vocabularies and constraints that you're going to be passing. And to some degree, when you're talking about portability of an electronic health record, you're really just talking about a much larger data set, but in my mind, it's just a continuum of the same kind of stuff you're talking about in transitions of care and data exchange with patients.

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

Larry, I was going to say much the same thing that I think where we can help both transitions of care and portability is in furthering the consumability of the payload for the different kinds of messages that we're talking about.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Interesting. So let me just ask you, because I remember from that workgroup there was a small team that investigated and then came back and said, well, there's certainly that part of it, but they said there's a whole other dimension to it which is really much like saying I'm going to change operating systems. And at a high level that feels like, well, they kind of do the same things, but then you actually try to do it and it becomes really squirrely really fast.

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

Well that's probably true to the degree that the data models are significantly different and one of the nice things, I think, about CDA for example is that you flatten out the data model into a reference model, and to the degree that one side can produce it and the other consume it, you've...much like you can produce an Excel document on a Mac and read it on PC.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, I agree.

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

I mean, for example, the way we here at EPIC have tackled the problem, obviously just in a rudimentary way so far, but when somebody wants to take...when a provider wants to take their patients records and go to a different system, we let them export a CCD with discrete data and then a series of PDFs.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Are you saying that people leave EPIC and go to other systems?

(laughter)

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

No, I'm saying that the requirement to be able to do so is often significant.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, so...

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

Thank you for allowing me to clarify that.

(laughter)

**Micky Tripathi – Massachusetts eHealth Collaborative**

This is a public call.

**Steven Stack – American Medical Association**

What you really meant was, when people come to EPIC from others.

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

That's right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, so what I'm hearing is that portability...in a way, portability is sort of in the scope of this, but it's really an extension of the other things that we're going to be working on anyway. Is that fair?

**M**

Yes.

**Lawrence Garber – Reliant Medical Group**

Yeah, I would say so. And again, I think it's smart to harmonize around at least this being able to generate and consume something like CDA, and obviously, when you're transitioning if you want to go above and beyond that, then you can and that becomes more of an issue between the vendors and the client. But, at least there should be some minimum level of data portability and the CDA is a perfect model for that.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay. Okay, great. So, it sounds like we have some tweaks to this that I got. The ones I got are that we should...there was some broadening of the context of the patient facing stuff or the patient engagement stuff to think of it more as sort of patient self-management or patient-driven communications and perhaps consolidating those as well, but sort of a general broadening of that. And, let's see, and then in the incorporation of some missing types of transactions that are going to be important supporting transactions like consent processes, interactions with the MPI, provider directory, PKI, a number of those kind of supporting services.

**Lawrence Garber – Reliant Medical Group**

You might want to add audit trails in there as well.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. And not the word...this is not carved in stone obviously, so we'll keep revisiting this I think. Okay, why don't we move to the next slide then.

**Lawrence Garber – Reliant Medical Group**

Micky, the only other thing I wanted to add on that e-Prescribing was formulary issues, maybe more clear definitions of formulary.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. I mean after all the work we did on formulary, how did we miss that. Because we consider it done, after all that work. Okay, great.

**Michelle Nelson- Office of the National Coordinator**

Hey Micky, this is Michelle. Before we get to the next slide, I just wanted to say, we'll have to figure out as we start to talk about process, a lot of these things are at least items that the Meaningful Use Workgroup has started to talk about in some way. So, and these are kind of divided up within the subgroups of Meaningful Use, so quality and efficiency is their subgroup one and so forth. So, we probably need to share...and some of the groups are a little bit further along than others. But as we think about process, we probably need to share at least where they're at and kind of make it a continuous process as they update what they're doing, that the IE Workgroup knows what's happening, so there's not a ton of overlap between the two groups, but at least...

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, that makes sense.

**Michelle Nelson- Office of the National Coordinator**

Okay.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So, you are hoping that we would only have to interface with the continuity of care sub-workgroup but now seeing that we're going to have to interface with like all of them.

**Michelle Nelson- Office of the National Coordinator**

All four of them, yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. You don't have enough work to do, so...

**Michelle Nelson- Office of the National Coordinator**

And just a quick note, they cover e-Prescribing within their quality and efficiency, I'm not sure where that belongs, but just something to think about.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh, okay. Yeah, I think e-Prescribing I dumped into public...merged with public health just because it wasn't obvious where else to put it. So, in the next slide then, we're proposing these three sub-workgroups then, which follow exactly from those groupings. And first off, does that make sense, to have them...it's not a perfect fit; we don't want to have too many sub-workgroups and so, three feels like a good number and I want to have at least the bullets. And so those categories have at least some kind of relationship to each other, although it's hard to group things into three and have everything be totally related and coherent in that way.

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

I think it makes sense although I'm not sure that the public health workgroup should work as hard as the others, that is, I don't think that simply because there is workgroup that we should assume that they're going to be several criteria that we're going to recommend. I'm kind of pushing against the idea of broadening our purview too far into the public health realm, and again, much like I described on the last call, I think we should really shore up our capabilities around transitions of care and related topics.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay. So, you're not saying that we shouldn't have a public health group, just recognizing that there's probably a lot more work in the other two.

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

Yeah. Maybe they should meet one third as often.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Michelle Nelson- Office of the National Coordinator**

And just kind of to...on that same idea, I think the public health workgroup, that's probably where there is the most overlap with the Meaningful Use Workgroup, so maybe that's just one meeting.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, right. Seth isn't on the phone, Amy's on the phone, so Amy sorry, go ahead.

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

No, I was just going to say, actually the maybe the way to do that is to take what the public health workgroup under Meaningful Use has come up with and use that as a basis and have one meeting with the whole group and discuss that. Because there is a lot of health information exchange in most of those components. So as opposed to creating another one, you know what I'm saying.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, yeah.

**Michelle Nelson- Office of the National Coordinator**

Yes, just have the two merge essentially? Have the...

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

Yeah, I mean either...I mean, that group is further down the road, but take...I mean I think the next time we have a call for that group tomorrow right?

**Michelle Nelson- Office of the National Coordinator**

Right.

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

And then maybe what we can do tomorrow is propose that we either merge or we take whatever...what we've done in that group and...I mean, we have to cross-fertilize anyway, and share it and then use that as a jumping off and say agree, disagree, want to add or don't add. Like why start all over again when we already have done all that work and we've been meeting for a while now in that group.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So, that's perfect.

**Michelle Nelson- Office of the National Coordinator**

Right, I mean, and to some extent, some of the other groups we definitely need to share because we don't want you to start all over again from work that's already been done in those other groups as well. But, to Amy's point, public health probably is the most overlap and it would probably make sense to have a shared call and could probably get it done. But, we can figure out how that works.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay, so Amy, you're on that workgroup, the Meaningful Use one.

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

Yes, I am.

**Michelle Nelson- Office of the National Coordinator**

She's on the public health one, yeah.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Great. Can I nominate you to be our lead on our side, since it's not really going to be that much more work?

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

I will do my best.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Excellent.

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

I will tell you that I am like the next couple of weeks, I am so swamped under with some other stuff, but I will do my best and it shouldn't be a lot more work. I mean, I'm literally thinking taking what that group has done and either taking a subgroup of this group or having us discuss it at one full meeting, and I think we can decide, do we agree from this group's perspective, disagree, want to add, want to take away and go from there.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, no, that's all I'm thinking. It's like probably one call of just the IE Workgroup members and to share with them where the Meaningful Use Workgroup recommendations are, where we agree, do not agree, and then facilitating that discussion with the entire IE Workgroup. That would be it.

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

I'll be happy to do that.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Great. Thank you. All right, one down, two to go. So, on the other two, now I realize there's a very small number of people on the call here. So, does anyone have any preferences for either leading one of these, being a member on one of these? We're going to have to have an offline process anyway, I think where we reach out to the entire workgroup, but, I want to give anyone the opportunity, if they'd like to reach for the ring right now...(laughter). It's there, it's dangling in front of you.

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

This...go ahead.

**Lawrence Garber – Reliant Medical Group**

Okay, this is Larry. I'd be willing to co-chair the care coordination one. I don't think I could lead it myself.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh great. Great. Co-chair is great.

**Jeff Donnell – No More Clipboards**

This is Jeff Donnell. Because I'm a patient engagement guy, I'd want to be a part of that one as well.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, can you two co-chair that one then?

**Lawrence Garber – Reliant Medical Group**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

All right.

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

...I'll gladly be a member. Peter.

**Lawrence Garber – Reliant Medical Group**

Can we have three co-chairs?

**Micky Tripathi – Massachusetts eHealth Collaborative**

I was going to say...all generals and no soldiers...

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

This is Chris Tashjian, I'll do the e-Prescribing or public health.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh, okay. Great.

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

I'll work on it. Again, I can't lead it, but, I could co-chair it with somebody or just be a member, either one is fine.

**Micky Tripathi – Massachusetts eHealth Collaborative**

That would be great.

**Michelle Nelson- Office of the National Coordinator**

Micky, can I suggest again to move the e-Prescribing up to quality and efficiency, especially if we're going to do public health the way we talked about with Amy, because there isn't much overlap in that area with public health.

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

If we're going to do that, I'm more interested in the e-Prescribing and so will move to quality and efficiency.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, all right, why don't we do that then. Great, so we have our first member of the quality and efficiency.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Micky, this is Cris, I can move on some of the e-Prescribing stuff. I'm really overwhelmed with Standards and Policy Committee commitments elsewhere, but if necessary, I'd be happy to help in coordination stuff on e-Prescribing.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Great, I understand. Yeah, thanks, I think any nuggets you can give us...any nuggets of time you can give us on that are much appreciated.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

All right, it's mostly coordinating back to people at home base to provide expert advice and so on.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. And I know, for the administrative simplification, Charles Kennedy hasn't been able to attend many meetings, but I'll reach out to him directly and see if he can take that one on. That's an important one and I think we need someone who's more focused on the payer side for that. Okay, we have initial lists, I think from everyone here, and then we can do a broader reach out to the entire workgroup to get those populated and get some meetings set up. So, next slide please.

So, in terms of what each of the sub-workgroups are going to do, the first thing I think is just again, thinking of it as very practically that we've got the Stage 1 and Stage 2 proposed objectives, all right. So I think that the first pass would be looking at those and saying, how did those existing ones get expanded in any way. And all of you I think have been through the drill now from Stage 1 to Stage 2 already, so you kind of know how that works, with every one, there's just a practical question of recommendations of extending any of those. And then, the second thing would be, are there any new objectives to be created to try to help further the broader goals that we're talking about here with some of these transaction types and some of them, as we know, aren't going to be covered at all by the existing objectives. So, we're going to want to have an eye toward that. And then, another part again, you've all been through this, so you've seen how this works to the extent that there's any clean-up recommendation that we want to make around deleting or consolidating, that would be sort of another one that I think of as more housekeeping. But, certainly the first two of expanding the existing ones and generating new ones, would be the main work of the sub-workgroups. Which I think will be, I assume, with Kory and Michelle, we'll have some...we can generate some templates that we can work from.

**Michelle Nelson- Office of the National Coordinator**

Yup.

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

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. So, next slide. So then, there's the other dimension on this is we want something, some hooks to hang things on, right, at least some criteria that we can sort of be asking ourselves, what's the goal of all of this, what are we trying to accomplish. And are there some goals that we want to be able to enable from a policy perspective by the...with respect to the objective and the functions that we're talking about here. So, this is a high level list that I think was generated by Paul Tang, the co-chair of Meaningful Use Workgroup, as a set of criteria that they themselves are going to be using. And I assume that it's still under refinement as well, but wanted to share this and we can sort of modify this any way we want, but it seems like a good starting place. And as you can see, there were sort of five key objectives they've talked about; does it support a new model of care in whatever way you think about that, there's some listed there. Does it address the national health priority? Broad applicability, I guess the idea is, we want to be broadening out to covering specialties, so patients and then recognizing variation across the country and being able to address that. Not topped out, does that mean that we could have some objectives that we've done all that we can do and there's no reason to try to do any more there, is that kind of the idea of that Michelle?

**Michelle Nelson- Office of the National Coordinator**

Yeah, that was it.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Or not already driven by market forces. And then, finally, the question that we talked about before is...we will get into this question of recommending things and then asking ourselves, well, is that a reasonable thing to ask for, even for Stage 3, given where technology is. And we'll have this sort of conversation back and forth, I think, about the maturity of standards, maturity of processes. So, what do people think of this?

**M**

If Paul did it, it's got to be good (laughter).

**Micky Tripathi – Massachusetts eHealth Collaborative**

Exactly. Since it's all going to go through him anyway...

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

Well, since I'm on that committee, I support it because I think, and actually from a different perspective, I think the more we can be consistent and look at this in a consistent manner, the more we will...obviously I think again we can add or delete if we don't agree with it from this committee's group. But, I think it's a great starting point and I think it does help frame things in a way that we can at least be a little consistent on how we're thinking about it.

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

It makes sense to me and it seems like for each of the criteria that we expand upon, keep or add, that we should document how these criteria apply.

**Michelle Nelson- Office of the National Coordinator**

I would suggest using a similar template to what the Meaningful Use Workgroup is using, so that when we go to bring them back to the Health IT Policy Committee, there's consistency across both groups.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay, is it a good template?

**Michelle Nelson- Office of the National Coordinator**

Well, I don't know, but...

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

It's at least interoperable, don't worry about the...

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

It's a little busy, but it works, and it has what you were talking about before Micky, in terms of, sort of the Stage 2 recommendations, what the HIT Policy or Meaningful Use Committee said, what was recommended for Stage 2 and then what people are thinking about for recommending for Stage 3.

**Micky Tripathi – Massachusetts eHealth Collaborative**

All right, it's really hard for me, but I'll greatly resist the temptation to create a new template. Okay, well that's great. So, we have some tools that we can use right out of the gate. Okay, well I think that's it. I don't know, the next slide should just be about next steps, I think. Yeah. So, are there any other thoughts or comments, I think we've accomplished a lot here, and we've got some sub-workgroups, we've got some folks already on them. I think we have a pretty good framework; we'll modify the one that you see here and distribute it back out and we'll send out a note to all of the workgroup members to solicit membership and leadership of the sub-workgroups and we'll start getting schedules for those sub-workgroup meetings.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Micky, this is Cris; this is more of a question than any sort of comment. I agree with everything that's gone so far. I'm really a little reluctant to raise this, but, given the fact that there's an RFI for NwHIN governance and an NPRM expected over the next couple of months, do you have any thoughts or comments about how we should be thinking about that, if that NPRM comes out?

**Claudia Williams – Office of the National Coordinator**

Hey Micky, this is Claudia. Do you want me to offer a couple of thoughts?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Please. The rest of us...

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right, I hate raising those kinds of questions, until Claudia answers, then I feel better.

**Claudia Williams – Office of the National Coordinator**

I think governance is going to be on...just given that we are...I would think we just ignore that and react to it as we need to, because I think it's going to take a while to put out the ANPRM and this cycle is a pretty rapid one. But, if you think about our first set of recommendations, the really initial ones, and, let me get the chart to be sure I'm still tracking against what I think, but are due in August, right. And at that time, most likely we won't have the final rule in front of us. So, I think the thought is that as the final rule gets published at the end of the summer that would give an opportunity to all of the workgroups to just do their cross-check against what their assumptions were, and make any tweaks that they want. They'll be a lot of in-depth work that's going to be done after that Policy Committee in August, so, they'll be a chance to do that kind of like level...and tweaking and reset, once the rule comes out.

I don't know, Michelle, what guidance other groups have been given, but one thought I had would be to assume that the framework of the rule and most of the objectives remain...just as a point of assumption, to sort of assume we're working from a base of the NPRM and working from there. Obviously there may be some things that change, but, that at least provides as set of decision rules for how to think about the next step.

**Michelle Nelson- Office of the National Coordinator**

Right.

**Claudia Williams – Office of the National Coordinator**

So, I guess it's forge ahead assuming the NPRM is largely the final rule, make recommendations in August, do the reassessment once the final rule comes out and then that'll then form the more in-depth work in the fall.

**Micky Tripathi – Massachusetts eHealth Collaborative**

And so that was speaking to the Stage 2. So...

**Claudia Williams – Office of the National Coordinator**

I just think governance is going to be on a cycle of, I'm not exactly sure when we're saying that the NPRM comes out, but that'll even just be an NPRM, so, I wouldn't hitch this process in any way to governance. I mean, I think when those things come out, we'll have to assess how we want to deal with it, but I don't think we know enough right now to have any kind of dependency.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Claudia answered your question Cris, we'll be in a crash exercise during the December holidays to align all of that.

**Claudia Williams – Office of the National Coordinator**

Now wait a minute...that's not what I said.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

You know some day it's going to be crash over like Groundhog Day or Arbor Day, and not like Fourth of July or Christmas.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Claudia Williams – Office of the National Coordinator**

It'll be Columbus Day, how's that?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Way to go Claudia. Thanks for that answer, I appreciate it.

**Claudia Williams – Office of the National Coordinator**

Or...you know, in Massachusetts, right?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Great. Any other final thoughts before we turn it over for public comment?

**Michelle Nelson- Office of the National Coordinator**

Micky, this is Michelle. I have one more thought. Sorry. I was just looking back over the draft list on slide 6; one of them is about quality reporting.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Um hmm.

**Michelle Nelson- Office of the National Coordinator**

And that probably makes sense for there to be coordination with the quality measures group, because that's where they're talking a lot more about that. And so maybe we could do something similar with them, I'm not sure if there's a member on both those groups, like we're going to do with Amy. I'll look at those...the lists and see.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Why don't we offline Michelle, maybe we can sort of figure out the mapping of our sub-workgroups to theirs and then figure out what's the best strategy.

**Michelle Nelson- Office of the National Coordinator**

Okay.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay, well, unless there are any other comments, let me turn it over to MacKenzie.

**MacKenzie Robertson – Office of the National Coordinator**

Sure, operator, can you please open the line for public comment.

## **Public Comments**

**Caitlin Collins – Altarum Institute**

Yes. If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We do not have any comments at this time.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you.

**Micky Tripathi – Massachusetts eHealth Collaborative**

The public is stunned into silence again. Okay, well, let me just thank everyone, I think we accomplished a lot today and really appreciate your joining. So, we'll talk soon.

**M**

Sounds good.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks everybody.