

**HIT Policy Committee
Information Exchange Workgroup
Transcript
June 6, 2013**

Presentation

Michelle Nelson – Office of the National Coordinator

Thank you. Hi. This is Michelle Consolazio Nelson with the Office of the National Coordinator, and this is the meeting of the Health IT Policy Committee's Information Exchange workgroup. This is a public call, and there will be time for public comment built into the end of the agenda. As a reminder, the call is being recorded, so please identify yourself before speaking. I'll now take roll. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative

Here.

Michelle Nelson – Office of the National Coordinator

Peter DeVault?

Peter DeVault – Epic Systems Corp.

Here.

Michelle Nelson – Office of the National Coordinator

Jeff Donnell? Jonah Frohlich? Larry Garber?

Larry Garber – Reliant Medical Group

Here.

Michelle Nelson – Office of the National Coordinator

David Goetz? James Golden? David Kendrick? Charles Kennedy? Ted Kremer?

Ted Kremer – Cal eConnect

Here.

Michelle Nelson – Office of the National Coordinator

Arien Malec? Deven McGraw? Stephanie Reel? Christopher Ross? Steven Stack?

Steven Stack – American Medical Association

Here.

Michelle Nelson – Office of the National Coordinator

Chris Tashjian?

Chris Tashjian – River Falls Medical Clinics

Here.

Michelle Nelson – Office of the National Coordinator

John Teichrow? And Tim Cromwell? Okay. I will now turn it over to you, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Great. Thanks, Michelle.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

This is Amy Zimmerman. I just want to let you know I joined as well.

Michelle Nelson – Office of the National Coordinator

Oh, thanks, Amy.

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, great. Hi, Amy. So thanks, everyone, for joining on a summer – I was going to say Sunday afternoon. It feels like Sunday afternoon. On a summer afternoon. And we just have an hour today and what I was hoping to do is, you know, sort of reset us on the work for building up to – really starting the formal recommendation process for Stage 3 meaningful use recommendations related to information exchange. And to that end, what I've done is tried to, you know, take stock of where we are, put together a high level work plan for us to carry us through into September, which identifies some possible focus areas and then a rough schedule for how we might accomplish that with the three upcoming touch points that we have with the HIT Policy Committee, which is the July, August, and September meetings. And Michelle can correct me if I'm wrong on any of the – any of that.

And the idea is to – so to further that, what I've also done is put out sort of a straw man approach to thinking about one of the areas, one of the focus areas, which is query for patient record, which I think we would all agree is sort of the most complex and – but arguably the most important one that we have before us. And as I said, it's completely a straw man, so the idea is really to provoke your reactions and – as a way of helping us frame what are, you know, sort of the parameters of the discussions and the – and looking forward to the recommendations that we want to make with respect to this particular area.

And we can talk about, you know, some of the other focus areas as well, but the hope is that we can talk a little bit about the work plan, get all of your recommendations and thoughts on that, and we can come to a consensus on that, and then hopefully dive into at least the start of the conversation on query for patient record. Next slide, please. So next slide, please.

So just, you know, reviewing, we had three issues in the Policy Committee Stage 3 request for comment, as you all may recall. Those were the query for patient record, the provider directory, and data portability, each of which were EHR certification requirements only, whereas query for patient record was, you know, a meaningful use requirement, and presumably would have a certification component as well.

And one of the things that I think we want to think about as we sort of set our broad, you know, work plan, and try to identify what focus areas we want to drill down over the coming months, you know, we're certainly not limited to these three. These are just the ones that we had put forward for the request for comment. But in thinking about this, and I think we may want to just step back for a second and think, are there any market developments or lessons learned that would cause us to, you know, amend this list, either take something off or, you know, confirm the importance of them, confirm perhaps the priority of them, or perhaps add something to them?

So just one note that, you know, that would make is that, you know, certainly the market is very dynamic and exciting. You can take that in a good or a bad way, probably a mix of both. And the landscape – but it's certainly true I think that the landscape looks different now than it did even seven months ago, when the RFC was released. Some of the things that, you know, that occurred to me are, you know, first off, the demand for cross-vendor query exchange appears to have grown with the rapid growth of ACOs and ACO type activities, but I think it's – again, it seems to me that the capabilities for such exchange have not really kept pace with demand. And again, this is cross-vendor query exchange I'm speaking about.

So in addition, directed exchange as required for Stage 2 is certainly starting to take – starting to take shape, as vendors get certified for the 2014 certification requirements, or they start to put in place their plans to get certified and start to complete the development work, and start to put that – those features into production.

It also, though, seems that the role and functions of HISPs is still somewhat murky, as those models start to emerge. And, you know, and again, this is all, you know, open for discussion, but lack of standards, at least from what I can see, for provider directories and security certificates, appear to be, you know, an obstacle to more rapid progress. It doesn't mean there aren't other obstacles, but that seems like that's, you know, sort of a – one of the things that, for example, is driving the formation of Direct Trust, and the thought that, as you start to see HISPs emerging, each of them is feeling the need to have bilateral contracts, in part to resolve these kinds of issues. Again, these aren't the only issues that they have in front of them, but Direct Trust is an attempt to see, how do we take some of these issues off the table so that we aren't in a world where, you know, the two to the N problem, where every HISP is going to have to have some kind of bilateral contract with every other HISP.

In addition, industry projections suggest that 25 to 30 percent of physicians may change EHR systems in the near future. You know, who knows whether that's true or not, but, you know, but I've seen now a couple of – a couple of surveys suggestions that. And whatever that number is, even if it's, you know, 20 percent or 15 percent, you know, that suggests that data portability is an important issue. I think we knew it was an issue, an important issue, but, you know, it may be even more important than at least I was thinking that it would be.

And then finally, you know, demand for patient engagement is growing, and entrepreneurial activity is growing as well in those areas, so particularly in the area of consumer engagement. So it seems like there's a lot going on there as well that we might want to think about as we think about what our focus area should be.

Let me pause here and see if that resonates with all of you, if you disagree with any of it.

Peter DeVault – Epic Systems Corp.

Micky, the one thing that I would comment on is underneath your dynamic market observations, the first one, I definitely agree that demand for cross-vendor query exchange has grown tremendously, especially over the last year or so. What we have seen, which is very good, is that more and more EHRs are settling on the de facto IHE standards for doing that, and we have connections now with well over a dozen other EHR and HIE systems doing exactly that. So there has been some progress even in the absence of Direct meaningful use requirements around that.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Okay. Great.

Ted Kremer – Cal eConnect

Micky, I – it's Ted. I think it's a very good sort of snapshot of the landscape. The other thing that we're seeing, and maybe not related to query per se, but more related to sort of the ACO world, we're seeing more interest in getting unsolicited results on an alert basis into EHRs.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep.

Ted Kremer – Cal eConnect

And I don't know what that looks like and where that fits in, but I think that's – at least in our world, that's sort of a big emerging change for us.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Right. That's sort of the subscription model.

Ted Kremer – Cal eConnect

Exactly. Yeah.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep. _____ –

Ted Kremer – Cal eConnect

Because, again, the ACOs are trying to consume data to in some ways solve for the query problem.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Right. Right. Yeah. And I know Larry and Safe Health have done a lot of that in Worcester, Mass, as well. Okay. Great. Well, thanks for those thoughts. I'll – we should definitely add them in as a part of the background when we move forward with the recommendation package that we have. Next slide, please.

So given – you know, just taking a look at that, and, you know, it appears to me at least that the RCO focus areas are still consistent with, you know, kind of the aspirational goals of Stage 3, and the gaps that may, you know, still remain from stages 1 and 2, with the possible, you know, addition of the patient engagement as something that we may want to consider. So, you know, that'd be one question for all of you, is, you know, I think query for patient record I think we would all agree is something that we have to address. Provider directory, perhaps the support query, as well as directed exchange, that's already required for Stage 2. You know, we took one shot at that earlier, but it seems to me it doesn't hurt to come back and recommend to the Policy Committee that they recommend to the Standards Committee that, you know, no kidding, we really do – we meant it last time, we mean it this time. We really think that we need some standards for provider directories.

And then – and then as I noted, you know, data portability, I think given that there, you know, seems to be a, you know, significant if not growing need for cross-vendor data migration, and certainly as the industry matures, that'll just happen anyway. If there's a large shakeout in the EHR vendor landscape, which I think we would expect with any maturation of the industry, then we would see that anyway. So that seems like it's an important one to address.

But then, you know, patient engagement. What's – what comes after view/download/transit, if anything? It seems like that might be an area that we also would have the right people and the right policy perspective to be able to help in that area.

Mary Jo Deering – Office of the National Coordinator

Micky, this is Mary-Jo Deering. Can you hear me?

Micky Tripathi – Massachusetts eHealth Collaborative

Yes.

Mary Jo Deering – Office of the National Coordinator

Hi.

Micky Tripathi – Massachusetts eHealth Collaborative

Hi.

Mary Jo Deering – Office of the National Coordinator

I don't know if all of your members know that there is a new consumer empowerment workgroup under the Policy Committee, and the consumer technology committee under the Standards Committee, and they are both looking at the patient engagement area. And I think it would be very helpful to coordinate, and, you know, we can talk a little bit further about how to, you know, look at the work that might be involved, and see who's already trotting down, you know, certain paths. It certainly is most definitely a growing area.

And by the way, one of the things that – one phrase that we had coined is after VDT, it's VDT and CC, for correct and contribute, or maybe even just the one C for contribute, because there's a lot of interest now in the other directional information flow. But anyway, we'd love to, you know, make sure that we can coordinate across all of the workgroups who are interested in this.

Micky Tripathi – Massachusetts eHealth Collaborative

Of course. Thanks, Mary-Jo, and yeah, and I apologize. That's my oversight for not knowing, first off, that those groups were out there, and second, for not identifying that there is an interest there. Well, I guess there's a question for this workgroup about, you know, how deeply engaged do we want to get into that. You could certainly frame it as it is information exchange or it's not information exchange, depending on how you, you know, want to define information exchange.

Larry Garber – Reliant Medical Group

Well, one thing I can say there is a new – when they open up the CDA for – consolidated CDA for ballot in September, there is – there will be another document tag specifically to handle – actually, it may be a new header as opposed to a new document tag. I'm not absolutely sure. But it's a new standard for patients to be able to submit data. So it's patient generated data document type.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Larry Garber – Reliant Medical Group

And there are a whole slew of issues about authentication, and I don't know if those other two workgroups are addressing them.

Mary Jo Deering – Office of the National Coordinator

I don't know that they'll necessarily get into authentication, because that usually falls to either the privacy and security workgroup under the Standards Committee, or the privacy and security tiger team under the Policy Committee. But Leslie Kelly Hall has been working with the HL7 group that put the new consolidated CDA header in the ballot, and so she – and she heads the Standards' consumer technology workgroup, so she's been certainly keeping us up to speed on that, and it does sound like a very interesting development.

Micky Tripathi – Massachusetts eHealth Collaborative

Great. Okay. So I can certainly reach out to them and – with you, Mary Jo, try to – you know, try to understand where they're taking that, and if there are any gaps that we could be helpful with, you know, we're happy to contribute. You know, I think in the – for the – in the run-up to Stage 2, as I recall, we were involved in the conversation, and I think we had a recommendation that – and, you know, not that we were the only ones among the workgroups, but as I recall, we did have a recommendation related to making sure that the transmit function was aligned with Direct, given that the providers were required to do that as well. So we have, you know, input it into the consumer engagement part of the meaningful use architecture in the past.

So I guess that, you know, the work plan here then would suggest, you know, the first three, and then we can – just for this conversation, I can, you know, try to understand a little bit better where the patient engagement piece is, and where we might be able to contribute there, if at all. We certainly don't want to be, you know, sticking our nose in when we don't need to, because we've all got a lot of other work to do. And the three that – the first three are, you know, sort of big enough areas.

So in terms of, you know, what our timelines would be, for the July 7th Policy Committee meeting, we'd propose that, you know, what we want to do is recommend the priority areas, and, you know, sort of the parameters of our recommendation. So at a high level, what – you know, how are we thinking about these. And then perhaps present some preliminary recommendations on query for patient record and provider directories. That may be ambitious, but I would, you know, underline the word preliminary, with an eye toward at least just starting to give some, you know, sense to the Policy Committee of what direction we're headed in, and perhaps what, you know, what sort of the high level guard rails look like. And then, you know, leaving – reserving our ability to, you know, refine that over the – over the summer, with an eye toward – I think, and Michelle, correct me if I'm wrong, I think September is when the final recommendations are going to be vetted at the Policy Committee level? Is that right?

Michelle Nelson – Office of the National Coordinator

That's the plan right now.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. So it won't come sooner, hopefully.

Michelle Nelson – Office of the National Coordinator

No.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Excellent. Thank you. Okay. So – oh, could you go back one? There was – oh, yeah. So the last – so the last bullet here, we have two calls to prepare for the July 7th Policy Committee meeting. What I would suggest, if it's okay with all of you, and, you know, I know no one wants to do this, is that we – I would suggest that we schedule two more calls. And I just threw out there, you know, maybe June 14th, which is – which is two Fridays. So a week from tomorrow, and then we have one on the 21st, which is the week – which is the Friday after that, and then maybe one on, you know, on June 28th.

But really work hard to target getting our work done without the need for the last call. So the idea would be that, you know, June 6th and June 14th, you know, focus on the query for patient recorder and begin provider directories, and then the 21st, complete provider directories, or, you know, by the end of the 21st, complete both of them. Again, just with preliminary recommendations. And then June 28th, if all seems to be going well, we can just do away with the call and then work offline with an eye toward finalizing the entire thing for the July 7th meeting, recognizing that that week that includes July 4th is in the middle there, and we wouldn't expect to have a meeting that week anyway.

Larry Garber – Reliant Medical Group

In terms of the timing for the June 14th meeting, is there flexibility? In other words, I know that the standard time has been 10:00 to 11:00, and I do have a conflict, but I didn't know if it could be 11:00 to 12:00 or –

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. I'm pretty flexible. How –

Michelle Nelson – Office of the National Coordinator

Just looking at the SACA calendar, we can't do 11:00 to 12:00.

Larry Garber – Reliant Medical Group

How about 12:00 to 1:00?

Michelle Nelson – Office of the National Coordinator

And you can't do 2:00 to 5:00. And there has to be a buffer in between. So the only potential in the afternoon would be 12:30 to 1:30 or in the morning. I'm assuming you don't want to do it after 5:00 on a Friday. That's on the 14th.

Larry Garber – Reliant Medical Group

And I presume we can't do too early because of California folks?

Michelle Nelson – Office of the National Coordinator

Well, Paul Tang's on the West Coast and we do 9:00 meetings all the time, but he's not, you know, everyone.

[Laughter]

Micky Tripathi – Massachusetts eHealth Collaborative

Paul is superhuman, though, as we all know. So I'm sorry, what would be the morning option? Nine?

Michelle Nelson – Office of the National Coordinator

It looks like you could do between 9:00 and 10:30, assuming there isn't something tentatively being held, but that's what it looks like right now.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. What's the –

Caitlin Collins – Altarum Institute

That is actually available. There isn't anything on hold right now.

Michelle Nelson – Office of the National Coordinator

Thank you, Caitlin.

Micky Tripathi – Massachusetts eHealth Collaborative

I hate to do scheduling on the call, but quickly, for those who are on the phone, do you have a preference for 9:00 to 10:00 or 10:30, or 12:30 to 1:30? It would mean that Arien, who is not able to join the call today, he'd have to get up at 6:00 AM if we did the early time.

Peter DeVault – Epic Systems Corp.

This is Peter. Either of those work equally as well or poorly, depending on how you look at it.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Yeah. That's how I look at it.

Larry Garber – Reliant Medical Group

And me, too.

Chris Tashjian – River Falls Medical Clinics

From my standpoint – this is Chris – earlier is better.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

This is Amy, and I think on that day earlier is better for me.

Ted Kremer – Cal eConnect

Ted Kremer. Either works.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Michelle Nelson – Office of the National Coordinator

So Micky, did you want to –

Dave Goetz – OptumInsight

I'm sorry. This is Dave Goetz. I just – yeah, I just joined, so I'm trying to catch up. So it is on the 14th or the 28th we're talking about?

Michelle Nelson – Office of the National Coordinator

The 14th.

Micky Tripathi – Massachusetts eHealth Collaborative

We're talking about –

Dave Goetz – OptumInsight

Fourteenth? Thank you. I'm out that day.

Micky Tripathi – Massachusetts eHealth Collaborative

Oh, okay. So neither of them work for you. What were you going to suggest, Michelle?

Michelle Nelson – Office of the National Coordinator

I was just going to ask, do you want 90 minutes, from 9:00 to 10:30, just to have a little more time? Or do you want to do –

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. Let me do –

Michelle Nelson – Office of the National Coordinator

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah, why don't we do that? That seems like it works for everyone, and I'll send a gift to Arien.

[Laughter]

Larry Garber – Reliant Medical Group

He wasn't here.

Micky Tripathi – Massachusetts eHealth Collaborative

The gift I'm thinking about is a ...

Dave Goetz – OptumInsight

He's obviously not buying enough people enough drinks when they meet in person.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Okay. Next slide, please. And then we'll work on the 28th, just to get it on the books. But as I said, you know, I will definitely commit myself to trying to eliminate the need for that meeting. So why don't we just dive into the query for patient record? We've got a – we've got, you know, 35 minutes, and let's just see how far we get. And as I said, I just tried to – this is all straw man, so – and I wanted to put that on every slide, but I don't want anyone to think that, you know, that I'm – that they're being railroaded here. This is really just all straw man, and, you know, want to get your reaction. It seemed like the most efficient way to do that was just put something specific down and then let's all react to it.

So, you know, on the first bullet, I think as we know, you know, the query for patient record approach in the RFC was essentially rejected by the Standards Committee, not the first time that that's happened to us. It happened on that one as well. And, you know, if I was going to in one bullet characterize their comments as well as the public comments, their – it was about the need to simplify and generalize the recommendation. There was a number of comments on the public side as well as from the Standards Committee itself, saying that it seems like too complex a workflow, too much back and forth. Someone on the Standards Committee had said, you know, this is basically making electronic what the paper process is today, and, you know, why would we do that? You know, those kinds of comments.

And, you know, whether we agree or disagree with the individual comments or not, that, you know, was essentially the feedback that we got from the Standards Committee. So the – some straw man first principles for – you know, for query, perhaps based on this feedback, and again, this is, you know, I just want your reaction to all of this, is – but as I thought about it, I thought, well, all right, so how might we then, you know, sort of step back for a second and at least lay out some first principles?

So one might be, you know, that we try to build on the Stage 2 approach that allows use of Direct or organized HIE infrastructures. And again, you know, as we look at the way, you know, that was framed in the 2014 certification, as well as meaningful use Stage 2, it allowed for both. I mean, it certainly required Direct, but it certainly had the options for people who are in organized HIE infrastructures, and it's capable of using those to be able to substitute, in effect, you know, for some of the requirements. So, you know, you might want to think about that as, you know, as sort of an approach.

A second would be – I'll run down – I'll run through these very quickly, just so we have all of them, and then I'll pause for all of your input. The second is, you know, do we want to set a goal of having query and response happen in a single set of transactions? And the idea would be I've got a query that contains – it bundles up everything I would need for that query, and then a response. And then the receive – the data holding entity is able to assess, able to consume that, assess whatever they need to assess, and then respond accordingly. So, you know, again, just the idea being if we can set that as a goal. It doesn't mean that that's where we'll end up, but, you know, that we can lay that out as a goal.

That's – and then, you know, sort of what would be in those messages? What are the basic elements of them? And here's where, you know, I may be completely wrong on some of these things, so this is where, you know, all of you need to really weigh in. So the requester, you know, should be able to send an encrypted query message with a couple of components. One is authenticating information of the requesting entity and the ability to discover security credentials. Two, patient identifying information, whatever that collection of information is. Three, some type of representation of patient authorization. And then four, some type of information of what information is being requested.

And as we'll describe a little bit later, maybe that isn't as necessary as the other ones, given the limited capabilities or the highly variable capabilities that data holding entities will have for, you know, for the foreseeable future, to be able to respond to specific requests for particular types of documents, at scale. I mean, I recognize that, you know, that certainly happens within vendor systems and in selected cases across some, but it's certainly not uniform across the market.

Larry Garber – Reliant Medical Group

Is there a fifth bullet for intended use? You know, TPO, at least?

Micky Tripathi – Massachusetts eHealth Collaborative

So yeah, well, I guess –

[Crosstalk]

Larry Garber – Reliant Medical Group

You know, asserting that you're going to –

Micky Tripathi – Massachusetts eHealth Collaborative

– you need that – would you need that if you have the patient authorization?

Larry Garber – Reliant Medical Group

Well, I suppose – I don't know.

Peter DeVault – Epic Systems Corp.

One way that we can frame this is that this is purely for the purposes of treatment, and that's actually helped us – or helped our customers get over some hurdles that they otherwise would have had if there were multiple potential uses for the data.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Let me – Larry, I – and I would suggest that we come back to this, and I'm sorry Deven's not on the phone, but one of the things I address in a later slide is that some of these areas were covered by the privacy and security tiger team, so that might be an area where we're actually able to leverage what – the work that they did there, and that was approved by the Policy Committee. They didn't speak to it, you know, this specifically, but for certain things like what is the level of assurance, was the terminology we were using there, and that may have had bundled up in it the authorization, as well as the intended use.

Larry Garber – Reliant Medical Group

Right. Because I know they did work on directed queries, so –

Micky Tripathi – Massachusetts eHealth Collaborative

Yep. Yeah. We did directed and undirected.

Larry Garber – Reliant Medical Group

Yep.

Micky Tripathi – Massachusetts eHealth Collaborative

So – and then the data holding entity, so now they've received a query message. The data holding entity should be able to respond to a query message by A, validating the credentials and decrypting the query message. Now, again, there may be HIE infrastructures where you're just doing, you know, a TLS, and that's fine. Again, you know, that could be a – just a variant here. They need to be able to match the patient. They would need to be able to verify the authorization for patient information. And then finally, be able to respond with some type of secure message either containing the requested information, or some type of reason for not fulfilling the request, and those might be, you know, details as a part of the – you know, the overall requirement.

So those are – you know, so for number 5 here, again, we're just on first principles, it seemed that there was, you know, also a lot of feedback that said, you know, don't over-specify. And with a – you know, with some concern that you don't want to enable – or because that doesn't enable or motivate new workflows, and also because it may not be flexible to variation or changes in key inputs. So for example, if you have something that's highly scripted related to consent, how is that going to be flexible to – you know, to the state variation that we know exists, or variations in, you know, substance abuse, or symptoms of conditions, or what have you.

And similarly, with the type of information, some, you know, systems may have the ability to respond to a specific request for lab data, whereas others may only be able to give a response of, you know, a medical summary, and that's all they're going to give for any kind of request, regardless of what the request is. And that may be a policy decision or a technology decision. But those seems like areas that we may want to, you know, leave a little bit open to flexibility.

And then finally, and this was – you know, I actually addressed this earlier. You know, we want to try to build on the already approved privacy and security tiger team recommendations on patient matching and query, targeted and untargeted.

So let me pause here and see if there are thoughts. You know, please take whacks at this.

Peter DeVault – Epic Systems Corp.

Yeah, Micky. I'll take the first set of whacks, if that's all right.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay.

Peter DeVault – Epic Systems Corp.

This is Peter.

Micky Tripathi – Massachusetts eHealth Collaborative

Be gentle.

Peter DeVault – Epic Systems Corp.

No worries. So a couple of things. One, I think, just in general, to the extent that there's a perception that the original proposal was overly complicated, it's probably due in large part to me trying to include the idea of discovering the record-holding – record holder's authorization form somewhere, whether that was at the record-holding site, or some server that served up those. And that did introduce a couple more round trips. Obviously, it was meant to solve some real problems around query response, but I think to the extent that what we're trying to do is make this simpler and easier for people to understand and maybe implement as a first pass, removing that set of – removing that piece of it would be a first good step.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Peter DeVault – Epic Systems Corp.

Specifically about some of the things that you've written here, I think if we tried to do query response based on Direct, rather than simplifying things, we would actually be complicating Direct significantly. I do obviously think that there are some well-known and used standards that are already out there, and that we probably shouldn't try to recreate them on a different sort of track.

I think there's merit in the idea of combining some of the transactions. So the IHE transactions, there are really three, right? There's the do you know about this patient, and given this patient, what information do you have about them? And then given that list of information available, please send me this subset. Certainly it's possible to, you know, working with IHE or whatever standards we end up using for this, to combine some of those transactions and situations where it would make sense, and maybe even have the ability for systems to either send combined transactions or individual transactions as necessary, where systems are able to do that.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep. I think those are great comments. And –

Larry Garber – Reliant Medical Group

This is –

Micky Tripathi – Massachusetts eHealth Collaborative

Go ahead. Go ahead, Larry.

Larry Garber – Reliant Medical Group

Well, I mean, I do agree with Peter that, you know, where standards exist, they should satisfy this purpose. But I do also hear, you know, what you were saying, Micky, which is that, you know, isn't there an even simpler way? I mean, I think about, you know, what we're setting up with one of our local emergency rooms here. You know, they're going to – they basically are sending us an ADT message saying that one of our patients is in their emergency room, and we echo back with a CCD. And, you know, that we send by Direct. And, you know, they're sending us, you know, essentially an assertion that you – that they – you know, that the patient's consented to this, and that – which is how it got to us in the first place. They're sending us the patient identification information. You know, we know who the requesting entity is, and we know the type of information that they want, because it's an emergency room. And we just send it right back.

And it's a single, you know, bam, bam, push, push, no – you know, no discussions, you know, no manual interventions, you know, no picking documents or the right patient. If they get a hit, we send them something. If we don't get a direct match, we don't send them anything. And it just – and that's the kind of stuff that will satisfy, you know, 90 percent of our needs, and would also – is easy to implement. So, you know, I'd love to be able to see more of that going on around the country.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Peter DeVault – Epic Systems Corp.

So Larry, this is Peter. A couple of reactions to that. I agree that most of the time, simply sending a response – or a query and getting back a CCD is going to solve most of the problems. And in fact, that's what most of the interoperability we see going on in the query response realm is doing. What I would suggest, though, is that same kind of – the interaction flow that you just described can and should be done with standard transactions, like those found in the IHE stack. What you're doing in your system is essentially you're getting an HL7 message, or – I assume it's an HL7 message, and then you're doing application level work to interpret that and put together the CCD and send it out.

In – so you're basically kind of re-rolling the set of standards that can do that sort of out of the box. I worry that – and I'm not exactly sure where the HIT Standards Committee reticence to seriously consider the IHE profiles comes from, but I worry that we're taking something for which there are very well-thought-out standards, and rather than trying to modify them to fit the case that we're trying to build here, that we're trying to cobble together something that wasn't intended for the purpose to begin with. But I like your – I do like your idea of rolling that set of transactions basically into one, so the query comes in with the patient demographics, and the assertion of patient authorization or whatever else needs to be in there, and then the response includes the patient CCD.

Larry Garber – Reliant Medical Group

So can that be done with one fell sweep with IHE?

Peter DeVault – Epic Systems Corp.

So we've modified – within Epic, we've modified some of the IHE transactions so that we are rolling those into essentially two transactions, because we have – we do two instead of one, because as you know, Larry, we've got that patient authorization step in the middle. But if we were to sidestep the trying to get the patient authorization in the middle of the transaction, we would in fact be able to go down to a single transaction, still based on that – the IHE profile.

Larry Garber – Reliant Medical Group

Cool.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep. So I would just point out, and I think those are all, you know, points very well taken. I think as the Policy Committee, though, we – you know, sort of our job is to talk about, you know, sort of the functions and policies related to where standards are needed. But the Standards Committee sort of, you know, is the – within their purview is to, you know, define what standards would be used to perform the function, and within the policy recommendations coming out of the Policy Committee. So –

Peter DeVault – Epic Systems Corp.

Well, to that end, then I'd suggest that we remove the reference to Direct.

Ted Kremer – Cal eConnect

Yeah, that would make sense, I mean, if we're not going to give guidance on how to do it.

Micky Tripathi – Massachusetts eHealth Collaborative

Sure. Yeah. And that's totally fine. The only reason I had for putting that in there was that it's something that was already approved, so just pointing out that there may be an infrastructure there that, you know, that we could leverage for query. But I think it's totally fine to remove it.

Ted Kremer – Cal eConnect

I would tend to agree, though, that moving Direct into the query model could be more challenge than not, than using the IHE piece. One question, though, just for me – because I'm sort of coming at this from the side. We're assuming the EHR will query. Are we assuming that the EHRs will respond to queries, too?

Peter DeVault – Epic Systems Corp.

Definitely.

Micky Tripathi – Massachusetts eHealth Collaborative

Yes.

Ted Kremer – Cal eConnect

Okay.

Larry Garber – Reliant Medical Group

Agreed.

Micky Tripathi – Massachusetts eHealth Collaborative

So – and that gets us to the next slide. So unless – let me just pause here. I know there was a lot on this slide, so let me make sure that there aren't any other thoughts or comments on this.

Larry Garber – Reliant Medical Group

Well, the other – I mean, the other issue that's sort of buried in here, and I – and to some degree this is what Deven had been addressing with her group, is that, you know, if – you know, I'm the one that's doing the querying, and I'm going to assert that I obtained the proper authorization from the patient. But in reality, as Peter knows very well, the proper authorization is not what happens in my state. It's what happens in the state I'm requesting from, as the record holder.

And so when Indianapolis, Indiana, who just follows HIPAA, sends a request to Massachusetts that, you know, has – goes away above the floor of HIPAA, then, you know, how in the world are they going to be obtaining the proper consent, when – and assert that to me?

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Right. Right. Yeah. So, you know, I think – my sense on that is A, I think that that's where we have the privacy and security tiger team recommendations that we would need to, you know, sort of incorporate here, because those are approved recommendations. And they basically pushed that – I may be wrong on the details, so we'll look at that and certainly ask for Deven's interpretation. But they basically pushed that to the end points and said, you know, that's going to be – the level of assurance that you need is the responsibility of the data holding entity to confirm.

And, you know, I guess that also strikes me as being the right thing, given that, you know, it's – you can't solve all the problems all at once, and solving for the five to ten percent of cases could drive us all bananas, and, you know, and leads to incredible complexity, just as we were describing before, whereas if you, you know, sort of have a model like that, for example, it may just be that the way the system starts to unfold is you've got a request, you know, at Reliant from Indiana. That's the one that you stop and say, I need a person in the loop to figure that one out. But the request from Beth Israel, I just – you know, I automate that completely.

Peter DeVault – Epic Systems Corp.

Yeah. I –

Larry Garber – Reliant Medical Group

Or what we could –

[Crosstalk]

Peter DeVault – Epic Systems Corp.

Micky, that's probably the way to go. I mean, obviously, there are ways to solve the problem, but to the extent that the Standards Committee or others aren't ready to go that step yet, I think the process that you just described is probably the right one. If a request comes in from a known entity or an in-state entity or whatever the rule is, then it can be responded to automatically. Otherwise, it might have to drop to a queue for somebody to work.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Peter DeVault – Epic Systems Corp.

It's unfortunate, but it might be the simplest way to get going on it.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep.

Larry Garber – Reliant Medical Group

But, you know, it's interesting. You know, as – you know, as each of the states are moving forward with their health information exchanges, you know, I think that they're starting to come to the realization that gee, it would simplify things if at a state level there, you know, was a standard acceptable consent. And if that's happening in all 50 states, and they all publish them, then, you know, it could – there could be a website we all go to when I need to request something from New York or California to get the standard state consent, and I can assert that I obtained it – I obtained the standard state consent, and call it a day.

Peter DeVault – Epic Systems Corp.

And Larry, that's exactly the – that's exactly what we originally proposed.

Larry Garber – Reliant Medical Group

Yeah, I know.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

[Crosstalk]

Larry Garber – Reliant Medical Group

Actually, we talked about an electronic version, as opposed to just go to a website.

Micky Tripathi – Massachusetts eHealth Collaborative

I am – as an American, I am incredibly touched by your faith in such a thing happening.

[Laughter]

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

This is Amy, and I was going to say the same thing. I think it's going to be a long time before we're at that level. But the other thing I wanted to say was, you know, maybe it's not ours as the Policy Committee to solve, but, you know, for these EHRs, unless it's customizable that on the end that's received the query that has to give back the data, you know, to be – sure, I mean, they're going to have to put – every implementation then is going to be somewhat different, based on – unless it's sort of – if the request was in state or out of state, because of the variations.

So I'm still struggling, thinking about how the receiver of the query would actually – how the system or the EHR would know whether to send, and how that would be if it were a single – you know, I don't know that I can see that as a single transaction now.

Peter DeVault – Epic Systems Corp.

Well, I think it might not always be able to be a single transaction. I think in the simplest case, where there's either trust built around the request out of band, so to speak, through a contract or through a DURSA or whatever it might be, and possibly it's in state, so there's similar rules around authorization collection, and all you're trying to get is the CCD, I think it probably could be in a single transaction.

For more complicated things, or if you're trying to pick and choose from available information, there's maybe no easy way to do a single transaction. And –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

So I think that's the challenge with the CCD, is if there are state specific laws on sensitive information ... banned from being in the CCD, it's going to be a challenge. But I – you know –

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Peter DeVault – Epic Systems Corp.

Well, that's why the record-holding system would have to build that CCD based on its knowledge of those rules.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. And we touch on this – I touch on this a little bit later, in – two slides from now, so let's come back to that, Amy.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Okay.

Micky Tripathi – Massachusetts eHealth Collaborative

I don't – I don't have any great answers for it, but I do touch on it. So unless there are any other – why don't we move to the next slide? Because it's really just a – you know, sort of a little bit more of a visual depiction of, you know, of what I was describing there, where, you know – so again, just looking at the components, so first off, a requester would, you know, in some way have to have access to the provider address and security credentials, in order to send something in a – in an encrypted fashion, in a secure fashion. So that may be where you have the ability to leverage the infrastructure being created for Direct, or not. That was sort of my thought on Direct, not necessarily following the full applicability statement in all of its details for query.

But then, you know – I won't walk through each of these, but you can see it's basically got the same components that I was describing before, where the idea would be if there's some way of doing it in a single back and forth, bundled up in, you know, whatever type of message. You know, we do a simplified IHE type of approach, or some type of, you know, RESTful approach or something as we move forward.

Peter DeVault – Epic Systems Corp.

I'm going to make one more comment, and hopefully for everybody's sake it'll be the last one on this – this particular –

Micky Tripathi – Massachusetts eHealth Collaborative

No, this is great.

Peter DeVault – Epic Systems Corp.

– this particular topic. But I think we might be making way too much out of the idea that it's a single transaction that makes everything simpler. Just about every EHR system out there that people have heard of is already implementing one or both of the IHE stacks so that they can interoperate with HIEs as well as directly with other vendor systems. And it's working quite well where it's working. So, you know, I wouldn't want our focus to be on trying to shoehorn everything into a single transaction. If it needs to be two transactions, that might just fall naturally out of the specification of the information flow that we want to have happen.

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Larry Garber – Reliant Medical Group

I guess, you know, that brings up an interesting question. So what exactly is that we're, you know, supposed to put into meaningful use or certification criteria? You know, are we – are we going to get down to the level of, you know, detail, saying that it's going to be one transaction or two? You know, that it has to be Direct or IHE? You know, or are we really just saying that this is what we want generically? And then if we are so generic, will we move the industry in the same direction to make it actually work?

Peter DeVault – Epic Systems Corp.

Well, unfortunately, by the time it gets to developing testing criteria, they will end up become very specific about how it will work.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. So I think there's two parts to a response, Larry. One is what – you know, what's the Policy Committee piece of that, and I think from – you know, from the Policy Committee perspective, you know, I could imagine recommendations sort of along the lines of some of the first principles, although, you know, better stated, and a little bit more of a logical flow, perhaps without as much detail, but, you know, saying things like we should, you know, try to minimize the number – you know, standards should have the minimized number of back and forths, and, you know, as much automation as possible, for example. We don't, to Peter's point, don't have to necessarily specify that it should be done in a single one. Maybe we can specify that that can be a goal. But, you know, but leave it to the Standards Committee on things like that.

But – and from a policy perspective, that whatever it is, it does need to cover these areas, authentication, authorization, patient identifying information, type of information, again, as concepts and functions, but without specifying exactly how that's done. But then the Standards Committee picks that up, and to Peter's point, will, you know, get to whatever level of granularity they're going to get to. But if it is going to be a requirement as a standard, as a technical requirement, the testing criteria is where the rubber meets the road.

Larry Garber – Reliant Medical Group

Thanks.

Ted Kremer – Cal eConnect

So I'm still stuck on this as an HIE piece, where I'm familiar with what happens when an EHR sends an IHE query to me. When we start thinking about an EHR responding to a query, does that mean that they're going to – they're necessarily going to need to create a fair amount of robustness in the EHRs to be able to do that patient matching that we do as an HIE?

Peter DeVault – Epic Systems Corp.

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative

Yeah. I would think so. Or –

[Crosstalk]

Peter DeVault – Epic Systems Corp.

To some degree it's already there.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Some are already there. Arguably, they could leverage the patient matching that's done by the HIE through some kind of web call or something, but that would be, you know, different ways of implementing that. But they're going to have to have – be able to access that, I would think.

Peter DeVault – Epic Systems Corp.

But that functionality exists for other purposes already.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. Labs and stuff.

Peter DeVault – Epic Systems Corp.

Yeah. So for when you go to create a new patient record in just about any EHR system, it's first going to try to check to see whether that patient already exists.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep.

Ted Kremer – Cal eConnect

Okay. Great. Because I'm – the use cases that we've been kicking around here, and I guess I'll wait for meaningful use 3 to support it, is where the health plans have been looking to try and do a query into an EHR for the soon or someday to be released QRDA type CDA document.

Peter DeVault – Epic Systems Corp.

Oh.

Ted Kremer – Cal eConnect

And I've been standing on my head, thinking how an EHR would respond to that query, but I guess through this it would, then, right?

Peter DeVault – Epic Systems Corp.

Yep.

Micky Tripathi – Massachusetts eHealth Collaborative

Yep. So why don't we move to the next slide, because I think we've covered most of what's on this slide? This is the last slide. So this is, you know, getting to – as we think about this, if we – you know, if that sort of is roughly accurate in terms of the broad outlines and what some of the particular components are, I just tried to give a little bit of perspective on each of them. So, you know, what do we need to specific in policy? And that's really – this is really sort of, you know, what do we as a workgroup need to drill down into in the way of recommendations related to policy in this area? So – and again, this is, you know, all straw man. There's a lot of question marks in here, so, you know, welcome all of your thoughts on this.

So in terms of discoverability of provider information, so I am a requesting organization, and I want to request something of a data provider, a data holding entity. I want to have, you know, an address and some credentials to be able to encrypt my query message. So, you know, it could be building on Direct. Maybe we want to leave that out, you know, and, you know, make a more generic statement. But perhaps talk a little bit about provider directory requirements, and that – you know, that's a separate issue for us, but I think that, you know, you can see how provider directories enable query as well as directed exchange.

Peter DeVault – Epic Systems Corp.

Yep.

Micky Tripathi – Massachusetts eHealth Collaborative

The second would be, you know, authentication. You know, is there a way of, you know, building on either Direct or the Direct infrastructure? Maybe we can say that or something, rather than the standard itself, but just recognizing that there is infrastructure being built to support that. You know, Direct Trust has a model out there. Certainly organized HIEs, like in Rochester, have different ways of doing that, so don't want to leave them out.

In terms of authorization, the Policy Committee has already approved the tiger team approach of placing responsibility in the end point. So I can get more of the details on that, and perhaps have Deven comment specifically on it for us, so we can get a good perspective on, you know, what they covered and what they didn't, and whether we think that there's anything more that we need to say on that. And then I think as we discussed before, that, you know, variation at state and organizational level policies suggests a need to, you know, kind of leave this open for now, anyway.

In terms of patient matching, the Policy Committee did also approve tiger team recommendations to not place requirements on patient matching approaches. Again, we can – I can go back and try to dig out those details. I forget the details of it, but I do remember the recommendations. And, you know, and sort of – you know, kind of a corollary to that would be that the data holding entity would be ultimately the – you know, where the determination is made of the level of assurance needed to establish a match.

And then in terms of the type of information, and this is getting a little bit at what Amy was asking, I think, you know, again, you know, we may want to leave this open to account for an absence of standards, and very high variation in the capabilities of data holding entities to respond to granular requests. Just, you know, here in Massachusetts, for example, there are large, complex hospital systems that I know are all over the map. There are some who are saying that, you know, we would and could respond to our granular requests for just labs, let's say, or just operative notes, whereas others are saying, you know, the way we would respond to a query is a lifetime medical summary, each time, just like Larry was describing. You hit me with a request, I hit you with a standardized, you know, medical summary on that patient.

If – perhaps if some type of specification is desired, you know, we might want to think about setting a minimum threshold respond, you know, such as a lifetime medical summary aligned with, you know, CCDA content requirements or something like that, or maybe there's a redacted BlueButton, you know, kind of, you know, kind of approach, and by redacted meaning – you know, because BlueButton has all sorts of stuff in it, because it's directed at patients, so taking out sensitive information or, you know, what have you, as a part of that generic response, for example.

I'll just cover the last two goals and then I'll pause here. I know I'm saying a ton of stuff, but it's got a lot of issues associated with it. Sensitive conditions may be too difficult to tackle system-wide, again, due to state variation. And just as Peter was suggesting before, this may be just the responsibility of the data holders to assure that such information is not contained in the responses that they automate. So you automate your responses to those who you trust, and then you don't for those who you just may not have a good understanding of what the rules of the road are.

And then finally, you know, using case-specific responses, such as for care coordination or, you know, different types of use cases, again, just may be too difficult to tackle system-wide. It does seem to be a very large jump from current capabilities. But that said, you know, I don't want to – I'm just, you know, throwing that out as something to react to, rather than, you know, sort of stating it as if it's a fact.

So let me pause here and see if these – this is the last slide, by the way. Just directionally, what's all of your sense on any of these components?

Larry Garber – Reliant Medical Group

I like – this is Larry. I like all this. And the one thing I'm just wondering is should we go one extra step and offer the ability to **plant** the subscription? In other words, could the authorization say – not just be a – you know, send me now, but I now subscribe – I assert that I have authorization to subscribe going forward?

Micky Tripathi – Massachusetts eHealth Collaborative

Right.

Larry Garber – Reliant Medical Group

You know, technologically, it's not that much different, but it really opens up this peer coordination piece amazingly.

Micky Tripathi – Massachusetts eHealth Collaborative

Right. That's interesting.

Peter DeVault – Epic Systems Corp.

You know, I think we could go that route. I differ a little bit, Larry, with you on technology whether it's much different. It's – that could end up being significantly more complicated, and to the extent that we're trying to make this palatable for people who are afraid of complication, it might – you know, I think we can propose it, but maybe propose it under separate cover, if you will.

Chris Tashjian – River Falls Medical Clinics

Yeah. This is – this is Chris. I've been pretty quiet all meeting, just kind of trying to take this in, but I think the more variability you throw in there, and the more options, the less likely it's going to work. I mean, to be honest with you, this has got to be fairly simple, if it's going to be able to be reproducible across multiple states and multiple vendors.

Ted Kremer – Cal eConnect

The other thing, too, is if you've got the component pieces, different organizations could build out those use cases with those standards. So it doesn't preclude that sort of subscription model.

Peter DeVault – Epic Systems Corp.

Yep.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

I couldn't – this is Amy. I couldn't hear the last person's comment, only because I'm in the car and I didn't get a good connection. But where would – if somebody – you know how like you can do different, you know, HIEs can get to be certified components for certain things? Have we thought about whether if an HIE is participating and sending data into ___ EHR ___ into an HIE, what – could the HIE take a role here as a certified component to be the responder and releaser of data in lieu of the HIE, or would – in lieu of the EHR, or would this all have to be – I mean, I can understand if it's a query from an EHR to an HIE and back, but if it's an EHR to an EHR, I'm trying to think about where ___ HIE ___ type function –

[Crosstalk]

Micky Tripathi – Massachusetts eHealth Collaborative

In general, I don't think – in general, there's nothing here that rules that out, in the same way that they can for the 2014 standards, and for meaningful use Stage 2. But, you know, but there are some parameters, you know, on it. So for example, you can use an HIE – an organized HIE for – as a certified, you know, relied upon software for, you know, your Direct transport requirement, for example, but it does have to be delivered to the – to the receiving entity. You can't just send it to the HIE and have it sitting there –

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Right.

Micky Tripathi – Massachusetts eHealth Collaborative

– and say that that counts. It does actually have to be delivered. So there – you know, there are some parameters that I think are a part of that. But you can certainly have that as a part of either relied upon software or just as part of, you know, how you put together whatever your own EHR technology is for your attestation.

Peter DeVault – Epic Systems Corp.

Mm-hmm.

Amy Zimmerman – Rhode Island Executive Office of Health and Human Services

Okay. I'm trying to think if that simplifies or makes things more complex.

Micky Tripathi – Massachusetts eHealth Collaborative

So yeah. So I know we're getting to the end of the hour here. What I would suggest – next slide, please – is I can take these comments and then perhaps start to write out what might be sort of the outlines of, you know, sort of a high level recommendation statement, kind of based on what was in here and everything that I got, and then maybe we can take that up on June 14th, and that'll give some greater specificity to us in the way of, you know, what would a recommendation statement kind of look like, if that makes sense to everyone.

Peter DeVault – Epic Systems Corp.

Yeah. Sounds good to me.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. So I think we've got, you know, the June 14th call, sounds like we've got a – you know, a time for that. I'll break the news to Arien. And June 28th, maybe we can offline – you know, Michelle, is that something that you or someone –

Michelle Nelson – Office of the National Coordinator

Yeah. Caitlin for Altarum is already on it.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Great. And then – and then we'll try to – you know, as I said, continue the query for patient record discussion, and perhaps begin the provider directory discussion on the 14th. So let me turn it over for the public comment, but first I want to thank everyone for your engagement and for joining us and for a great conversation. I thought this was really helpful. And for not beating me up too badly on the – on my straw man.

Michelle Nelson – Office of the National Coordinator

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

Public Comment

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press star 1. Or if you are listening via your telephone, you may press star 1 at this time to be entered into the queue. We have no comment at this time.

Micky Tripathi – Massachusetts eHealth Collaborative

Okay. Great.

Michelle Nelson – Office of the National Coordinator

Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative

Thanks, everyone.

Peter DeVault – Epic Systems Corp.

Thanks, everyone.

Larry Garber – Reliant Medical Group

Thanks. Bye bye.