

HIT Standards Committee Transcript August 22, 2013

Attendance

The following members attended the meeting:

- Dixie Baker
- Anne Castro
- John Derr
- Lorraine Doo
- Floyd Eisenberg
- James Ferguson
- Keith Figlioli
- Lisa Gallagher
- John Halamka
- Catherine Hong for Steve Brown
- C. Martin Harris
- Leslie Kelly Hall
- Stanley Huff
- Elizabeth Johnson
- Arien Malec
- David McCallie, Jr.
- Kim Nolen
- Jonathan Perlin
- Wes Rishel
- Kamie Roberts for Charles Romine
- Eric Rose

The following members were absent:

- Jeremy Delinsky
- Rebecca Kush
- Anne LeMaistre
- Nancy Orvis
- Christopher Ross
- Sharon Terry
- Andrew Wiesenthal

Presentation

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

Thank you. Good morning everyone, this is a meeting of the Health IT Standards Committee. It's a virtual meeting. It will be a public call and this is the 50th meeting of the Standards Committee. There will be time for public comment at the end of the call. As a reminder public comment is limited to 3 minutes. Also as a reminder this meeting is being transcribed and recorded, especially because everyone is on the phone today if you could please be cautious and try to state your name before speaking it would be appreciated. Also for those that are tweeting, it is hashtag hitstandards for today's meeting. And with that I will take roll. Jon Perlin?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Good morning.

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

Good morning, Jon. John Halamka?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I'm here.

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

Good morning. Anne Castro?

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

I'm here.

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

Arien Malec?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I'm here.

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

Martin Harris?

C. Martin Harris, MD, MBA – Chief Information Officer - Cleveland Clinic Foundation

Present.

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

Cris Ross? David McCallie?

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

Here.

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

Dixie Baker?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I'm here.

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

Liz Johnson?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I'm here.

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

Floyd Eisenberg? Jamie Ferguson?

Jamie Ferguson – Institute for Health Policy/Kaiser Permanente

Here.

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

John Derr?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Here.

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

Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Here.

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

Becky Kush? Sharon Terry? Stanley Huff?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Here.

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

Wes Rishel?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Here.

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

Keith Figlioli? Lisa Gallagher?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society (HIMSS)

Here.

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

Anne LeMaistre? Kim Nolen?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Hi Michelle, I'm here.

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

Good morning. Eric Rose?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Here.

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

Andy Wiesenthal? Jeremy Delinsky? Charles Romine?

Kamie Roberts – Associate Director – National Institute of Standards and Technology

This is Kamie Roberts for Charles Romine.

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

Thank you, Kamie, Lorraine Doo?

Lorraine Doo, MSWA, MPH – Senior Policy Advisor – Centers for Medicare & Medicaid Services
Here.

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

Nancy Orvis? Steve Brown?

Catherine Hong – Veterans Health Administration

Catherine Hong for Steve Brown.

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

Thank you, Catherine and with that I'll turn it over to you Jon.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, let me actually turn it immediately over to Dr. Mostashari. I'll make some comments about Dr. Mostashari, but obviously some important news in the interim and as a turnover just what a model of public service, support for public health and support for the public. So, Farzad I'd like to make some more comments afterwards, but want to thank you for your leadership and service and look forward to this next era and look forward to your comments to the committee.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Thank you so much. This is the first opportunity for me to speak to you all since announcing that I will be stepping down as National Coordinator. There have been a lot of very humbling things said in the past few weeks and I think two of those that have most touched me have been actually from members of the Standards community. Keith Boone actually who gave me the pain in the posterior award for public service and John Halamka's blog that was really, thank you John, very, very touching. But, I think both of those made me reflect on two fundamental misunderstandings that I have had in understanding myself and my career that I wanted to share with you. Sometimes it's those mistakes that we learn from the most.

The first mistake or misunderstanding I had on federal service was when I first joined the federal government, which was many, many, many years ago actually my first job out of residency was joining the Epidemic Intelligence Service of the CDC and I pictured myself wearing the CDC emblazoned shirt or jacket striding into an epidemic taking command. That was my vision of what federal service was about.

And as I worked at a public health department I learned that that is not at all what public service is, what federal service is, that in fact it's much closer to what the symbol of the Epidemic Intelligence Service is, which is a shoe with a hole in it as exemplifying work, the grinding sometimes but grading away of one's ego for the sake of service, service for its sake and not at all about aggrandizing the wearer of the shirt far from it and reminded me of the clinicians that I'd known who had holes in their shoes from walking the corridors of the hospital and the patient rooms and being there at 11:00 o'clock at night worried about their patients, that's service and it's that wearing away that makes us, I think, be able to shine as we clear away what's extra and extraneous.

My second fundamental misunderstanding was when I had first joined the federal government for the second time at ONC and I had in the intervening time in New York City developed some strongly held beliefs and positions some right, some not right, probably, but when I came into the federal government and I remember sitting in a meeting biting my tongue feeling that it was inappropriate for me to display passion, that it wasn't federal. It wasn't somehow elevated above the different, you know, stakeholder interest and so forth.

And I remember writing on a three by five index card “welcome to the federal government, check your passion at the door.” I couldn’t have been more wrong. And I called – I talked to my mentors, I talked to Tom Frieden and to David Blumenthal and I said, you know, I’m having kind of a questioning here about whether this is the right place for me and how to deal with my wanting to show and share what I feel strongly about and they both said, you know, you’ve got to be yourself which was really good advice I think.

And I think that’s some of what John pointed out is being willing to share the passion that I feel for the work that we’re doing and the meaning of what we’re doing I think for me has been something that I could offer. But it’s also what I’ve learned is that everybody has that passion. You wouldn’t last two minutes in any of our jobs if you didn’t have that passion whether you show it overtly or not. Everybody has that passion that motivates them and where we succeed is by linking within public service to the private sector, the non-profit sector, academics and others who wish to serve the same way and to link our passion to theirs, to yours.

And so, I’m always humbled, but especially now as I reflect on many I think undeserved, much undeserved praise and I really do want to assure everybody that everything that has been done has been done as a result of your work and the work of really the amazing committed staff at ONC who do serve and who do see service as their mission and their passion and that work will continue as I hope to join those on the outside now who will be linking my passion to yours. Thank you. That’s all I have to say.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, Farzad, thank you for those eloquent comments. Before I make some comments I’d like to turn first to John Halamka and in fact any other members of the committee who might like to make a couple of comments, but let me first turn to John.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, thanks so much and Farzad I meant everything I wrote, because I get to live the regulations in the trenches and I recognize that we would not have done the work of the last several years if you had not driven us especially around the public health and personal health record areas. Those were championless in many ways and so I look as I now prepare for Stage 2 certification at the foundation I have in place and it is in large credit to fine, if you don’t want to take credit for all the holes in your shoes you’re convening and your passion, so thanks.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Thanks.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Are there any other members of the committee that might like to speak?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes, this is Wes Rishel.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Wes, please go ahead.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I’d just like to say that perhaps for the first time in my life I heard someone say something like eyes on the stars, feet on the ground and changed that from an empty slogan to a modus operandi and it has been a great experience for me.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, this is Liz Johnson. Farzad it's amazing what you've gotten done and I think all of us sit in awe at the amount of progress and as the leader, as humble as you may be, we hope that you look back with tremendous pride at what was accomplished because healthcare today is better because you stood up. So, thank you.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie Kelly Hall I'd like to add to that. Farzad we've had many causes but the cause of the patient and engaging the patient was leaderless. You came in with that passion and taught us that you can do the right thing well and technology can help support that so thank you very much.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr. Farzad, I really appreciate the support and help you've done for long-term post-acute care. I've worked with all of the ONC since David Brailer and you're the one that stepped up and said, even though we don't get incentives we are important and you've got to support us and I speak for all of the people in long-term post-acute care and behavioral health that you did take the positive and also aggressive things to help us out and it's very much appreciated and good luck in your future endeavors.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, fellow members of the Standards Committee I have a resolution that I'd ask for your approval of, I'd like to read it out on behalf of the Health IT Standards Committee. The Committee would like to recognize Dr. Farzad Mostashari for his leadership and public service. Dr. Mostashari your public and population health perspective and your passion for improving all dimensions of the care of individuals is evident in your policy direction.

Your leadership and public health and public service and of the Office of National Coordinator has been as good as it gets. Your pragmatism and empathy have allowed you to lead an agenda as fast as required by our nations needs and deliberately enough to bring as many as possible along.

The outcome is a burgeoning ecosystem of possibility for the use of information to improve health care and value and you and the team at the Office of National Coordinator leave a legacy that allows everyone to keep their eyes in the stars and feet on the ground. The Health IT Standards Committee thanks you for your leadership and public service. So, are there any objections by any members of the committee to this resolution?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, so moved.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Here, here.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Hearing none, we recognize Dr. Mostashari and virtual clap.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Couldn't we work in there must be a horse in there somewhere?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

All right.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Thank you, thank you all, I'm glad this is a virtual meeting, so I can get misty eyed without embarrassment.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks for the passion you've brought to this and let me just acknowledge the passion of the entire committee of the ONC staff and all the people, because indeed I think what binds us in our activity is not only a policy commitment to improving healthcare and value but really a passion for improving health and welfare and appreciate the passion of everybody.

With that, let me transition to two orders of business. I'm going to dovetail a little bit shorter, first I'd ask – I know that Dixie I believe had a quick amendment to the minutes, but as Dixie mentions to us that amendment, I'd ask if anyone else has any corrections, amplifications or amendments to the minutes? Dixie Baker, you had a short change?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, I sent the mark-up, the word mark-up to Michelle it really was the – I think it was a transcription error it wasn't – I don't think it was anything substantial it was just to get the right meaning across.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, actually I've got it in front of me.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Oh, okay, good, I don't.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

In lieu of outside of the box solutions it was really both integration and usefulness of these data in reference to a number of criteria and pragmatic application. It is a change in the middle of page five, but as Dixie said it's really changes from colloquialism to just a reflection of the prior text.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Jonathan, this is Eric, there was a very minor correction that I would want to suggest.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Please?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

And I'm not sure what page it is on but the phrase pharmacies use a less precise categorization scheme should be PBMs use a less precise categorization scheme, it was a description of a comment that I had made.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, terrific.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Thanks.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay and there are a couple of others things sprinkled through in there that are just improvements of grammar or to make things clear with those changes, any objections to the minutes going forward? Great, hearing none we will declare consensus on those and let me turn to John Halamka to lead us quickly through a review of today's agenda content. I just note that Farzad as we sort of close the circle and honor you I think this agenda is particularly unique.

The Implementation Workgroup not only brings forward information from a hearing by in point of fact really provides insight toward increasing the interoperability, the application of the vision in place and expand it. Dixie Baker and John Halamka you pointed this out, boy if the work that the NwHIN Power Team summarized, and this is sort of closing the loop from a prior meeting, doesn't send chills up your spine I don't know what will because one really gets a sense not only of emerging capacity but the excitement the future holds and as always a terrific ONC staff describe really instantiation of all of this direction and the operating machinery of the organization and I think that really proves the point that passion and public policy really can intersect in productive work and appreciate all the ONC work under your leadership.

So, with that let me close those loops and pass the baton to John Halamka to introduce the agenda activities and perhaps flow right into the first session.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, great, thanks so much and as you said, Jonathan, we look very much to the discussion from Liz and Cris on the Implementation Workgroup Hearing and that July 23rd Usability and Implementation Hearing and what are lessons learned on issues such as user centered design, what are the key findings and pain points in the actual implementation of the applications and how have we done with some of the challenging Stage 2 requirements as we think about enhanced patient access, view, download, transmit, summary of care quality measures, some of the things that are pushing the envelope?

You know, as we, a Standards Committee, adjudicate standards that are mature for purpose and make recommendations to ONC, you would love to hear in a closed feedback loop how well or not well those recommendations actually in implementation were received by our various stakeholders.

So, I think we'll hear from them on interoperability, the state of HIEs and important questions of usability because if we create wonderful standards but yet the products are hard to use and the workflows don't really encourage interoperability we will not have achieved our goal. So, as you pointed out, for our 50th meeting, you know, this is like our golden anniversary here, we are going to get a wonderful summary and feedback from the Implementation Workgroup.

And as I also said, the NwHIN Power Team today does its final recommendations and you'll hear such things as what is the role of OAuth2 and OpenID, and FHIR, and RESTful transactions as we see what Amazon and Facebook, and Google have done to ensure interoperability among their ecosystems are there exciting possibilities not only for the consumer space but for all of the transactions administrative and clinical, payer, provider and patient? And so, I think we'll see from them some also extraordinary simplifications of what could be additional transport capabilities Stage 3 and beyond.

So, it's a short meeting, but a good meeting and then of course ONC will tell us about S&I Framework activities and where we are on the office of policy. So, look forward to those remarks and so hey, Jonathan if we want to plow ahead with Liz and Cris's remarks I think we are ready.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

John let's do it.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, hey, Liz, tell us about your hearing.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

All righty and good morning everyone. This is Liz Johnson. Cris is vacationing in Japan today so he won't be joining us but certainly has been influential in developing our hearing and the remarks that I'll make. So, we need our presentation up, please? Next slide, there you go. So, here I have displayed the work members, Workgroup members that consistently are there with us over and over to do all the work that you're about to see. In this particular hearing we'll talk about other Workgroups that joined in again, but always want to say thank you, they take time out of very busy schedules and their contributions are great. Let's move on, please.

So, today we're going to talk about, as the John's as we call them, introduce really what came out of the Implementation and Usability Hearing, it was an exciting day, absolutely cram packed with information and it is always good to sit with our colleagues from the industry that as Farzad has often said have their feet on the ground and are dealing with this and get their very candid and insightful comments.

And then Carol Bean will join us to talk about some more work that's being done on the test scenario development. As you may recall, this is the portion of certification that is currently voluntary that will allow us, we believe in the future, to really ensure that clinical workflows and what goes on in our care environment is reflected in our testing scenarios. So, if you'll go to the – flip past the title slide, please and then go to the next slide.

So, one of the things we wanted to start with this morning was really an overview of the hearing itself. The Implementation, Certification and Meaningful Use Workgroups all got together and on the 23rd of July held a hearing in Washington. There were actually 19 Workgroup members present from across the myriad of committees so they had an excellent showing, really committed and in present to actually work with the panels, ask questions and get clarification as we went through the process.

We talked about the topics that are listed. We looked at user centered design processes and a consulted agreement that had some information to bring back to us. We talked about the topic of usability which, as we talked about in the last Standards Committee, is one that brings up great passion and one that I believe in the future we will spend more time on as we've moved, you know, into those later life phased cycle where we know that the products that we put out there and the design that we use has to be workable in the clinical environment in order for us to really deliver what we want which is greater care to our patients.

We talked about healthcare exchange and interoperability, a topic that's near and dear to all of our hearts. As we begin to move out of the four walls that we all provide in everyday whether it's – regardless of the setting in which you work, we begin to recognize that the exchange of information is going to become an escalated need and certainly one that has great promise.

And then we talked with our eligible provider and eligible hospital partners and really got, you know, that, as John just said, on the ground you're doing it every day it's how you're getting certified, it's how you're making the regulations work. It's really that passion that comes from those people who believe in this program but want us to be aware of things that we could do that would improve our positioning for the future.

So let's move to the first panel, please. So, the first thing that we did was we got a report back from a group that was contracted by ONC, the National Center for Human Factors in Healthcare and there was a team of human factor experts that were sent out and they did visits to nine varied vendors and the concept there was that they wouldn't go to just the large vendors or just the small vendors but the hope was that they would cover a cross section sufficiently to be able to give us some insight into how vendors today were ensuring that the products that we use were user centered or at least the design was.

And in essence what they found was, and this is probably not a surprise to many of us, that the UCD processes really vary significantly. They came up with three classifications. There are certainly vendors that have no user centered design that can be identified as that. However, those same vendors frequently used their customer request to drive their design. The panel pointed out that that certainly is a responsive way of coming up with design but it becomes a – quickly becomes the method of – what I often say is responding to the squeaky wheel and so it's not as well defined it's more subjective than objective and so certainly, they are doing and trying to respond but they don't have a clear methodology.

The second set of vendor's understand the reasons for user center design and appreciate that it needs to be incorporated but they haven't been able to fully integrate it into their design processes. So, they're very early in the stages and interestingly we found that they often reflect, as did the first group, that their customer request still drive a great deal of their design.

And then there is a group of vendors that do this in a very vigorous way. They have very efficient and extensive infrastructures and testing, but it's really interesting even looking across all of those groups and as we continued with that panel for that hour it became very clear that there is significant confusion that exists between feature function versus usability, in other words, it's very clear when a vendor is given the opportunity to give back to us a particular function or feature, but when you really start talking about how does that work with the actual end user, the ability to do that as part of the design is much fuzzier and it's clear that often those designs, although well tested, and even may use focus groups, are not often beta tested to the point that we might desire in the environments where care is delivered.

It was also pointed out that the new release timing that we're dealing with today in order to meet the specifications that we're all working diligently to do so, really limits the time that they can get end user design input. So, while they're meeting the deadlines that we as – and I'll speak specifically to myself, as an eligible hospital, we have deadlines that we need those vendors to meet so that we can do our work so that we can get to attestation. And we're all concerned about making sure that as those products go in they are reflective of design, but we recognize that the timing has limited that significantly.

And then I think the final large finding out of that particular panel was there was a consensus among both those on the panel and those listening to the panel that we really should allow private industry to drive this. We've often had that debate about how engaged do we need our partners at ONC and others because they've been so helpful in helping us get to a better place we used to be. But, it was clear in this particular area that there was concern about how much regulation we want to put around UCD.

Now, what I want to do, you'll recognize I'm not pausing here to ask specific questions, is we want to get to the presentation and then we'll come back to the members questions or clarifications or frankly, since many of them participated certainly they can add comments.

The next couple of panels that we did were with our eligible providers and eligible hospital persons as well and those were both great panels. We had representation across a diverse set of physicians that represented the many platforms that are out there for use as well as the care environments that we deliver care inside of. So, we heard from academia, we heard from large urban, we heard from community and we heard from small practice. Really important to make sure that we weren't getting a picture that was slanted one way or the other but from all.

And so as we went through with that – and then I should say, I guess I should talk about the hospital providers, there we heard from a very esteemed group of CIOs that again represent a very diverse set of care environments but come together working diligently to make Meaningful Use Stage 2 readiness a part of what they're doing in their work, anticipating what Stage 3 might be presenting to us as future work and brought up a very key set of points.

I think one that I didn't comment here on the key findings slide that I want you to hear is, without a single exception the desire to continue to move forward, the appreciation of the fact that we have clearly made substantial progress all believing that much of that progress would not have been made without the work, without the regulations, without the work of these committees, without their work to really push forward the availability of electronic computing, the digitalization of the record just critical success and I think without exception they were very appreciative of that across the board.

They did however consistently state, for both groups, that there are some real challenges related in particular to the measures around patient access, view, download and transmit, summary of care and quality. And again, all believing that the intent of the measures is much of their organization's philosophies or their practice intentions but the difficulty of meeting those measures is really facing them today because the timelines are short and they're trying to make sure that they are continuing to practice and care for their patients while trying to get to these measures.

Another incidental but very important finding was there was a consistent concern about the timeline for the completion of the advanced work that is required to take a product from a vendor when they're ready to give it to the person whether it's an eligible provider or an eligible hospital and then getting the advance work done within their practices or care settings and then meeting the attestation window. So, again I think there was a clear balance between the desire to move forward and accomplish what has been asked, but an equally clear concern that the time that's been given is challenging and may not be sufficient.

The next panel that we had was our interoperability panel and, you know, it was an interesting panel; it was much more a sharing of tremendous –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Excuse me Liz?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

I think we're on the – oh, never mind, sorry, we weren't advancing the slides; I see it now, thanks.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, thanks, Leslie. I think the interoperability panel was one where we really heard a sharing of great successes where the proliferation of HIEs is astounding and that the functionalities between those although diverse are all moving towards beginning to set a world in which we can exchange information or make information available for going and getting, you know, even if it's not being pushed to you that will help us, you know, begin to move down that path of not being sole providers living in a very unique universe but instead taking advantage of providers inside and outside of our own networks.

There were lots of questions around how the vendor products were going to, as we say, stitch together to really ensure the secure transport between each other. One of the concerns that was raised, and again, as I give you back the hearings, these are not results that we have validated we are providing you with the insights that were provided to us, validation to follow.

But one of the concerns was, are the vendors working together and have we created an environment where there is some inducement to really work together to make sure that as customers of those vendors that we are not having to overcome that failure to work together and there were many suggestions as to how that might be remedied or at least investigated to determine the depth of the problem and the potential solution.

So, now we're going to move onto usability. This panel, again, was fascinating. I think that all of us spend a great deal of our time as we think about how we're going to accomplish the end goals of Meaningful Use, how are we going to ensure that at the end of the day we are indeed improving patient care? And this panel really spoke to, you know, kind of the state of the maturity of usability as well as, you know, some of the design issues and usability, oh, I would say barriers that we need to overcome.

The first thing is that one of the things that was consistent was that flexibility and design often creates a conflict with trying to reach our goal of standards. We know that we need to get to standards around transport and eMeasures and we know, as a, you know, certainly a guiding principle that is critical. But, what that does or at least was perceived to do was create some diminishment of the flexibility in our design option.

I think another thing is that it is clear that usability should be guided by understanding the users and their workflow in the context of work. Often we've talked about in this committee that while one may work in a laboratory however that maybe described if you're not involving the people that use the products and the actual functionality in a real environment, back to our feet on the ground, then often we can get lost in something that looks terrific and, you know, here at Tenet we have what we term a "war room" and we often design what we think are outstanding processes and as we take them out to the field we discover that they need some updating or changing, or altering to meet the needs of our users.

One of the things that came up again was that current testing and therefore design today in this current phase of product design often reflects measure criteria and compliance. And what that means is that as the vendors, with a short window, look at what they're going to need to change their product to do to meet the Meaningful Use measures, they frequently design toward that and that is complicated by the timeline and not bringing in the end users. So, you know, the concern is we want to be sure that while they certainly need to meet that measure criterion that they keep in mind the workflows and what our work teams need to be able to do.

It was pointed out that there is very little formal data that really is available on implementation and usability. There is certainly anecdotal data and there have been some studies, but some formal study of this would be very helpful in helping guide us as we go forward with more objective data.

And then finally, I think that additional, the criteria came up around, do we use certification criteria for testing? Is that the only answer? And with all the things that we're pointing out to and moving onto further stages what else could we be doing? And we know that the ONC is planning on and has been commissioned to look at surveillance.

So, one of the things that was discussed is beyond just certification criteria is there an opportunity for surveillance? Is it one where we can then work together to improve what we do? Is there an opportunity for deeming? Can we begin to talk about deeming some of the things that we do to show that we could actually meet a measure and then that would allow more time to go back and work on the usability challenges that we have today. So, next slide, please.

So, you know, as I've told you, we met for a full day and then actually we stayed and met for another half day and reviewed just enormous amounts of input and it's always very difficult when you try to, you know, bring that down to a very simple set of recommendations that you can act on. So, although these are the recommendations that came directly out of the hearing I can tell you that each one of the Workgroups in concert with our chairs will be working toward additional recommendations, but certainly, we wanted to ensure that there was a promotion in a very real way around usability by aligning testing and certifications and the plausible work flows.

You know, in a just a few moments Carol will join us and talk a little bit more about the clinical-based scenarios. We know there is more even to be done than that to ensure that the workflow does reflect what is needed to care for patients and that that workflow is not driven by the technology.

The second thing is there was an ask for identification of a few industry standards to promote safety and usability. The example that was given was tall man, sorry that should be a parenthesis, but I think there were several others and the idea was, are we comfortable that all the vendors in those very common uses of industry standards, particularly around safety, are doing the same thing and to ensure that that's something that as an end user or a product buyer we can count on.

And then finally, there was an ask or a recommendation, that we, through the work of many bodies, establish a normative time from implementation to Meaningful Use attestation from the time that the rule is issued. So, the concept there is can we work with ONC and can we talk about from the time that we know a rule is going to be ready, meeting a measure has now been enacted, prior to that can we determine the amount of time needed to actually build the products and get to implementation and attest using safe and effective workflows? So, obviously, number three is, you know, full of many opportunities for conversation and certainly for lots of work. With that, I would like to turn it over to Carol. Have you joined us?

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Yes. Can somebody confirm that you can hear me?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

We can hear you. I can hear you.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Okay, well that's what's important. Okay, thank you, I appreciate the opportunity to provide a brief update to the committee on the test scenario project. Could you move to the next slide, please? Thank you.

Just as a reminder it has been about a year that we've been working on this actively and last year in 2012 the IWG began advising ONC on development of test scenarios, content of test scenarios that could be used in testing the proposed, at that time, 2014 edition EHR certification criteria. So, to begin that process ONC and the Implementation Workgroup outlined four clinically plausible narrative test scripts for use in various patient care settings. Now these narratives were used to guide the progress that I'll discuss here and progress that we've made thus far.

A reminder of the specific objectives of the test scenario project, essentially, we want to align the test scenario development with the Workgroup and our overall objectives and interest in advancing usability. The test scenarios are intended to ensure that data can be used within systems, what I refer to as intraoperability as well as between systems or interoperability. We also want to use the test scenarios toward the end of making testing more efficient and more consistent for developers, as well as the test labs and to align the testing itself, testing of EHR technology with plausible clinical workflows that make sense in the setting. Next slide, please.

So, during 2013, which is slightly past halfway, we have made substantial progress on test scenario development. Using the test scripts that were developed, the narratives that were developed last year with the IWG's help this – developed approved concept for the test scenario process that included drafting a very detailed, very small, very limited so that we could test it, test scenario. We pilot tested that draft scenario with an ATL and two vendor developers and then used that to outline a refined process for developing further scenarios that can be used optionally in 2014 edition testing for certification.

Now the results of the tests, of the pilot tests were extremely positive. Feedback from the participants both on the lab side and the vendor side suggest, and as I said this is obviously a very, very limited sample, but suggests that using scenario-based testing could significantly reduce testing time for the 2014 edition products by possibly as much as half but if not that much very significantly.

And one of the things that we've seen with the 2014 testing and certification so far is that it is – because of the rigor and because it's more complex it is taking a lot longer to do, which is a good thing because we are far more assured for the results we get but it is a burden, so the participants noted the high potential for reduced testing time, as well as a reduction, and this may be as important if not more so, in the testing set up that has to occur prior to testing that would result from the use of this threaded data that is characteristic of this plan. Next slide.

So, after pilot testing we used the test script narratives that were developed in 2012 as well as input from clinical and policy experts at ONC to outline a clinically plausible workflow that essentially can follow a patient from contact with an eligible professional, hospital or critical access hospital through a care encounter and follow-up, a sample one or representative one, and then follows that provider, hospital or critical access hospital from patient care through public health and clinical quality reporting measures.

Now, it's important to note that this is one, possible workflow setting combination of the scenarios, but it does – the workflow that we're working on right now doesn't include all of the criteria. One of the features of this is that you can sort of pop things in and out so it doesn't require all of the criteria but it does include the ability to attest or to test all of the criteria. So, next slide. Thank you.

So, the IWG will review the clinical plausible workflow that ONC has drafted based on their initial test script narratives and the input that we received from ONC clinical and policy experts. As, I said I would like to emphasize, again, that it is only one way that the certification criteria could be linked in a clinically plausible workflow for testing. It doesn't imply that it is the only way. It also doesn't imply anything about how the providers and hospitals actually use the certified EHR technology. It is just a possible way that it could be used.

So, meanwhile, as we move forward, ONC is developing test scenarios that are aligned to that draft workflow. We are on target to make the draft scenarios, and it's a set of them, available to the public on our website right after Labor Day. So, we would like to have people review them, to review the process, review the specific scenarios, give us feedback. And following the feedback and whatever revisions and improvements that we are able to make we hope to be able to make those final test scenarios available as an optional method for testing technology against the 2014 addition certification by the end of this calendar year. As I said, we are on target for that. It's optimistic but I certainly think possible and that's basically the update. So, thank you.

Judy Murphy, RN, FACMI, FHIMSS, FAAN – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

Carol, Judy Murphy here, could you elaborate or clarify with the scenario that was already tested and these five draft test scenarios that will be out around September 6th will that then be all inclusive of what would be required if you were going to use the scenarios for doing all of the testing?

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

No this is the clinical side. We have – it will be a little bit more than half of what we're putting out in September is more the patient clinician side. The aspect of certification and testing that deal with the clinical quality measures and the public health reporting, what I think of as or what can be considered more, sort of – they certainly are clinical and related to the clinical encounters and activities but they are conceivably more administrative in nature so the public health reporting, some quality measure reporting that kind of stuff will come in a second set that will be – we are on target or on track to release those before the end of the year.

But what's coming out in September is a smaller set that focuses on all of the clinically relevant ones or the ones that are I think more patient-centered, provider-centered, clinical encounter. We had to look at them in some way and this is what we're having for September.

Judy Murphy, RN, FACMI, FHIMSS, FAAN – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

And then just to clarify how you're bucketing them into these six scenarios, I know the first one is intake. Could you describe briefly the other five? You know, how you grouped the workflow?

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Judy, I've got to admit I am sitting in the corner of a conference room in Nashville, Tennessee and I don't have that material. Is somebody from my team on that can just list the sets of clinical scenarios?

Scott Purnell-Saunders – Office of the National Coordinator

Good morning, Carol, this is Scott I'm pulling it up right now.

Judy Murphy, RN, FACMI, FHIMSS, FAAN – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

I just think it would be helpful to help people see the vision of how this is going to work.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Sure.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And while the –

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

–

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I was going to say and while that is being pulled up, I mean, Liz Johnson this is sort of a related question is as you did these hearings on the implementation reality did you hear back from any vendors or organizations that went through certification and made specific comment on how the certification process could be improved to address some of the concerns that you have outlined with usability, with ensuring workflow includes interoperability, are there things in the testing that seemed unnecessarily burdensome that might be replaced with the scenario-based approach that Carol has just outlined? Did you hear anything like that?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

We really didn't hear a great deal of that, John. I think this time as we put the hearing panels together we did not include the vendors and so although I've heard anecdotal and I'm sure you have, as well as other committee members, about those kinds of things and I would be glad to bring that back, because we do hear it in the Implementation Workgroup but we did not hear it as part of the hearing.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

This is Farzad, I just want to say from my perspective there are two advantages of the scenario-based testing. The first is, as John is suggesting, that instead of having unit based testing where you keep having to enter in data for patient after patient, after patient, after patient for different tests that the data that the next unit uses is the data that was just entered in the previous unit. So, it cuts down on the unnecessary busy work involved in the certification process.

But the larger gain is a confidence that in fact the assumption that many customers have of their Health IT systems is that if I entered in the blood pressure in the blood pressure section in structured data or the problem list or the medication list or whatever that in fact that is the data that is used in generating the registry list of patients with diabetes who, you know, have high blood pressure or that it's used in quality measure, or that it's used in the decision support, the drug-drug allergy makes use of the medication and the medication allergy that I just entered instead of having to have me reenter it.

And I still hear from customers that the actual implementation and maybe it's a configuration issue, maybe it's a development issue of their system requires them to do duplicate data entry, not just duplicate data entry one time for passing a certification test but duplicate data entry everyday they use the product and that not – you know, that's not great.

So, having a scenario-based testing provides that assurance to the customer that in fact the data used that's collected in one part of this workflow is used efficiently in the next part of the workflow and I hope it will become a little extra star, a little extra badge that customers will be looking for and expecting from their vendors that they will do the higher bar in terms of the scenario-based testing.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Do we have the six criteria ready to roll?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I have a question.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Go ahead Dixie.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

This is Dixie Baker. Liz, this has to do with your hearing which I thought was very interesting and very well done, very useful, insights came out of that hearing. It was one of the better hearings I participated in. One of the things that they mentioned, one of the participants, multiple participants mentioned, actually, is that the interfaces that they implement for data exchange each of them has to be hand built.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

And there is very much a need for standardization of these interfaces and some pointed out the cost of each individual interface that needs to be hand built and in some cases that becomes prohibitive. And another participant pointed out that view integration, which we've talked about here before, is much easier to implement than actually implementing the exchange of data and I personally would point out that the view is much safer from a security perspective because it doesn't involve actual data flow and replication of data.

So, I think it's important for us as we develop standards for query which is another thing they pointed out was very important to the physicians that we consider the utility and the ease of implementation for the view as a, you know, query to view as well as the query to exchange data both are useful and both are important.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Agree and I thank you for that comment and, you know, Dixie, it's one of those things and like you said, for those of us who had the privilege frankly of participating the insights were remarkable in this another one that's very helpful.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And as a corollary to that Dixie, because I've implemented quite a lot of view interoperability, I'm now getting clinicians that are saying, now of course, you have to save a copy forever of the data that I viewed in the EHR that did the viewing because what if I'm sued two years from now, how do I know I'll be able to replicate the same view that I used to make my decision? And so I love view it's easy, it's safe, physician satisfaction is high but there is a policy question on whether the view will remain unchanged in the system that has been queried if there is litigation or a subpoena or something that arises in the future?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Right, but I think – I recognize this, but I think in most cases the screen that is viewed is still a lot less data and, again, it's not data flow then a whole document is in general.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I pointedly agree with you, but we may need some policy guidance on this like the steward of the data because it is going to be viewed not only today but conceivably replayed in the future has some responsibility for data integrity.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well, I think that's – this is Wes, I think that's a topic that needs to be teased out more and I don't think right now is the time, but I did have a question for Carol if we're still waiting, if Scott's ready, let's let him go ahead with the information. Otherwise, I have a question for Carol.

Scott Purnell-Saunders – Office of the National Coordinator

I'm ready to go I was just waiting for you guys to finish your comments.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

You could wait a long time Scott. Why don't you go ahead I'll ask my question afterwards.

Scott Purnell-Saunders – Office of the National Coordinator

Okay, so as Carol described earlier, we bucketed the test scenario development into major sections. The first section she described or mentioned was the clinical section, the second one being administrative. Built into the clinical section we developed these five overarching buckets to kind of contain several different testing criteria by which it will cover most of the clinical interactions that one would see.

The first one was clinical intake which basically goes into looking at details related to demographics, vital signs, problem list, medication list and has a lot of the initial stages that you would see in the clinical information setting such that, you know, an intake setting, you know, of care where a patient would show up in a particular place add the particular detail and information that's needed and it would be entered one time.

The second one that we built in encounter interoperability intake which basically conducts your transitions of care and your clinical information reconciliation. The third would be the care ordering that includes your computer, a CPOE, your computerized provider order entry, your drug-drug allergy interaction, your pulmonary checks, your ePrescribing and the EMAR edit, electronic medication administration record process in the inpatient setting.

Section 4 would be the care results which looks at the clinical decision support, the electronic notes, image results and other pieces there. Then we have the final one which was the post-care as we're calling it including the patient list, the transmissions of care documentation and transmissions of electronic tests to ambulatory providers once the actual encounter has been completed and data portability and then the view, download and transmit to a third-party and secure messaging when needed.

Under the administration piece Carol described the reporting, the privacy and security in the system, those three sections are in development once we get the first slot complete. Essentially these sections are a lot more technical in nature and we bucketed them that way to allow for the clinical ones that are more related to how care is provided and delivered to be done and completed first because we felt that that would have the greatest impact in the quickest amount of time and could give us additional time to develop the administration pieces out specifically with encountering or encompassing the clinical quality measures, the amendments, the authentication access control and authorization inside the privacy and security and then the G1, G2 and G3, and G4 under the system sections that we described.

Now this bucket list that I've talked through will be available and will be disseminated as we start to publish the first section or the first five developed testing scenarios in early September so that folks can get an idea of exactly what's covered. In this you will see the buckets as I've talked about but also the exact detail of certification criteria which are covered in each.

One thing that Carol mentioned and Farzad mentioned as well is we had some pilots that were conducted this spring with the testing scenarios and the overarching feedback that we got was that everything was extremely positive and that the test labs were very, very much in support of this effort and that their timing to do testing as a whole was reduced significantly and the burden in some ways of reentering data and conducting similar tests with small changes was reduced significantly.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Wes, you had a question?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, I think, and first of all I think that this move towards scenario-based testing is important and I think that it's been done very responsibly in the sense of making it an option and bringing it in in sections so I don't mean my question to sound like a criticism of the current process, but we are at the point in a few weeks where some adopters of Stage 2 software need to begin testing cycles. There are options for how they are scheduled around and it's a complicated measure. But one would assume that vendors were targeting one September or if they're EHR vendors perhaps are targeting 31 December as the completion of their certification.

So, I'm wondering who will actually be the vendor, I don't mean the name of individual vendors, but sort of statistically, how many vendors will have the option to use these new testing procedures and what will we – and that's important because it affects what we learn going forward improving the certification process even more downstream.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Wes, I think that a couple of – response there. I think that we are seeing that there are some vendors who have completed certification and, quite frankly those are the one that we used, not all of them, but the pilot test vendors were taken from those who had passed the certification criteria, you know, that we were piloting for obvious reasons and they were the ones that were as, you know, enthusiastic as anybody, extremely so.

I think that we see right now people are, the vendors and developers, are taking a slightly different approach, perhaps a more cautious and measured approach to certification. So I don't think in having discussed with the test pilots and the certification bodies what's happening and how the vendors are approaching testing this time around testing and certification that by no means is everything going to be – are we behind the curve. We may be the initial ones have already done it but there will continue to be quite a large number of vendors and EHR technologies that have the potential to use the scenario-based testing so I don't think we have missed the train in any way, shape or form.

In addition, I think that, speaking to Farzad's point, that this – with scenario-based testing it's not just a check the box and do it faster, which it will check the box of the certification requirements, and also do it faster using the threaded data to cut down on the testing time, but also provide the assurance to providers that the data used in one place is actually that which came from another place in the workflow, the interoperability of the systems.

And so being able to designate their products as having gone through scenario testing actually gives them something more than a vendor can say, you know, here's proof that we can do this, you know, this additional thing which is not just meet the requirements in the base way but we can meet it in a way that uses the threading and demonstrates and proves so that the data – to the next, so that I believe that many of the vendors who have already certified will come back. And at least that's some of the indication that I'm hearing is that vendors who have already certified will come back and go through this scenario-based testing just explicitly so they can be able to say, yeah and here's the proof.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric Rose; I'd like to sound a little bit of a note of caution about that. It concerns me that this sounds like we – and by the way, I'm supportive of the idea of the scenario-based testing in general, I think it's great and I think you're moving along in a wonderful and robust, and careful fashion.

We have to be really careful that it does not become a backdoor way to introduce new certification requirements and, you know, we have a process established under statute that says that the certification requirements will be defined in regulation issued by ONC and subject to the same public comment processes as other regulations and if we want things like the drug-drug interaction checking to be based on the patient's medication list, which is something that I absolutely agree with, then that really should be part of the certification criteria and it's hard to write certification criteria that anticipates all the needs of end-users and that's what we have to do.

So we can't think of something later on and then, you know, kind of try to slip it in to scenario-based testing and I think, actually, we ought to proactively make sure of that and check with the vendors saying, you know, do you think there's anything in this scenario that implies a requirement over and above what's outlined in the Reg.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

I think that's an excellent point and it's one of the reasons that we are moving so carefully and why we're developing it in the way that we are this approach, because we can't add requirements and so where the juice is coming is through the data that's used and being threaded and how the things are hanging together but that absolutely is a concern is that we are not adding requirements and we're able to though say, but if you do it this way not only do you meet these requirements, but you can say a little bit about how those requirements were met.

So, and the other piece to that is not being able to anticipate or surely that's absolutely true and I think that the ability to link them together in various ways and why we said, you know, this is just one possible set of scenarios. Ultimately, you know, I would like to see a whole library of scenarios that could be used to meet the way that people's workflows do or to meet the way that the vendors have developed their products, but still meet the requirements that are established by regulation, which is essentially, you know, the cannon.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

So, Carol this is Jon Perlin and Eric I appreciate that question. Just one of the comments that's been made not only at the hearing, but prior to, is that certification, by different certification entities could lead to things are in fact certified but not necessarily compatible.

I think Eric's point is very well taken but just something that I think, you know, bears note is that the scenario testing and library of scenarios that you describe seems in my estimation to increase the likelihood of compatibility across testing processes which is of course one of the pieces of – which is of course the intent. So, that's terrific.

Hey, I just want to do a time check. We're coming towards the time that we had allocated but let's do a quick survey of additional comments, questions, etcetera. John Halamka, anything you want to start with?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

No, just absolutely applaud the idea of moving to scenario-based testing. I of course am a self-certifying organization which means that I get the joy of doing exactly the same work that EPIC and Cerner get to do but I have three people doing it and so I certainly am sensitive, Carol, to the points you've made.

I've actually had to create a separate server instance of our entire product line to do all the pre-data entry that is necessary for registering 28 patients and 47 labs and all the rest of this stuff. So, being able to do a workflow that says, well I am now registering Mr. Smith. I am now prescribing a medicine for Mr. Smith and I am now sending a reportable lab on Mr. Smith is a welcome relief.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, thank you.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

You're welcome.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Wes?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

This is Wes again, at the risk of being the same old hand – do you have another person that wants to comment there?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Is there anyone else who wants to jump in?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Yeah, this is Stan I'd like to comment.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Hi, this is Floyd.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Floyd, okay, so let's put a queue, let's have Wes, Floyd anyone else?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Stan.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Stan, okay, so let's be tight on the questions and we'll go Wes, Floyd, Stan.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, okay, I want to be sure that it's clear that I'm speaking for myself and not in any way echoing something that ONC has said, but my opinion is that there has been an underlying assumption about EHRs that drove a great deal of thinking of the entire Meaningful Use Program, which is that once data is entered into the EHR it is available for various benefits such as quality reporting, such as creating an extended system of healthcare providers through interoperability and so forth.

And it has been a matter of discovery to find that some EHRs tend to associate data with the template in which it is entered in their files rather than the more common method of a central store of data elements with time and a code to say what kind of clinical data it is and those EHRs do a lot more tap dancing in order to meet the requirements intent to meet just very specific requirements. We have a delicate balance to avoid getting into defining the architecture of EHRs. But where we can define an operational measure, such as there being, you know, one kind of blood pressure and not 20 based on which template the blood pressure was entered in making gathering data easier.

It's worth our using the full legal process to move certification in that direction and by the full legal process, I agree, we can't sneak in new criteria, but we are on the cusp here of getting to one of the things that I think has been most troubling in terms of realizing the benefits of proliferating EHRs.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Any comments anyone wants to offer to that? Okay. Then we'll take those comments that stand by themselves. I guess Floyd and then Stan we'll go to you. Thanks, Wes.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Sure, this is Floyd, so I actually want to – I actually am following a little onto Wes's comment. In recent work that I completed looking at implementation of the eQMs I think it's very clear that scenario-based testing would be very helpful as well in developing and testing the eQMs and other information required for them and decision support to avoid that issue of it's in one template and that's all that will be measured.

So, it's possible that rather than thinking of the quality measure reporting as a scenario, perhaps the development and testing of the measure content ought to be managed the same way that you're doing the testing for EHRs to avoid duplicate entry and hardwiring, just a suggestion.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, thanks, Liz, so you and Carol will take note of that and appreciate those comments, Floyd.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

We will.

Carol Bean, PhD – Director, Certification & Testing – Office of the National Coordinator for Health Information Technology

Yes, thank you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

And Stan?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Yeah, I apologize in advance for the poor quality of my connection here. My comment is actually probably more policy than standards. I think our focus should be almost entirely on two things on certifying – and secondly on outcomes. I think measures and other functionality certification stifles innovation and ultimately has not shown hence the quality of patient care and there are a bunch of reasons that I can cite around that, but I think we need to focus on those things instead of certifying functionality because I think if people are held accountable for the outcomes and they are held accountable for sharing data then they'll improve functionality through innovation and other means which will be better than assuming that we have the right answer and that the current functions are the best functions or the best way to do medicine that we know how to do today.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, any comments Liz, Carol?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, I think, you know, we really appreciate the input from the committee. I mean, the clinical based-scenarios are something that we, you know, started on like Carol said over year or a year and a half ago and I think it was at the urging of many of us that believe that's the right thing and I think the comments are clarifying and helpful for our future work.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, let me just applaud the Implementation Workgroup, you Carol, Cris and all the members for just terrific work in not only receiving feedback through the hearing but synthesizing that so eloquently and prompting a very thoughtful effective discussion this morning that will inform future direction and appreciate all the comments of the committee members in this area. Well, and I also thank you for your timeliness, because you are right on target and with that let me turn back to John Halamka to introduce the continuing conversation of the NwHIN Power Team.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, well, thanks very much and so we –

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

John, before you speak, I'm sorry I just wanted to add that the Implementation Workgroup, Scott and Carol and their team will work to get out a document based upon what they discussed and spoke to today following today's call. Sorry about that.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Fantastic, thanks, Michelle.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right, it would be very helpful to see those six groupings that were discussed.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, we've heard from Dixie and David in the past on their preliminary investigations of emerging standards, the work of MITRE, FHIR, the use of OAuth and OpenID. All will recall that as we looked at transport over the last several years we've looked at Direct, SMTP/SMIME, XDR, SOAP, REST and often the comment is made SOAP is an architecture not a standard. How could you implement via a standard implementation guide an architecture?

So, I think what we'll hear from Dixie today is in their investigation they have actually found combinations of mature existent standards and implementation guides which could suffice to give us a RESTful transport option for many purposes. So, Dixie, turn it over to you.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

All right, thank you, John. The slides please? This is, as John mentioned, we'll be presenting the final recommendations from the NwHIN Power Team. We originally presented our preliminary recommendations in June and today we'll be presenting our final recommendations. Next slide, please.

I first wanted to tell you guys that we have done a little updating of the NwHIN Team. As you know the topics that this Power Team has addressed have changed over time and I think that the interests of the people who are on it, you know, also change over time.

So, David and I decided that it was time to do an update and we did and the names that are in red on your screen now are individuals who recently have joined the Power Team and we're really pleased with every one of them. Keith Figlioli is one of our new committee members, Standards Committee members, and we certainly welcome him to the team as well as the others. Debbie Bucci is with ONC and she is our new technical support so we appreciate her help as well. Next slide, please.

Okay, what we're going to do today is first to review and update the task, remind you what it became after our last meeting, remind you of the preliminary recommendations and then present the results of our coordination with the Privacy and Security Workgroup and with the Consumer Technology Workgroup and then finally we'll give you the final recommendations.

As with many of the presentations that we give this presentation contains quite a few acronyms and I will try to define them as we move along, but they are all defined on the last page of your presentation as well. Next slide, please.

The initial task assignment from ONC was to recommend whether ONC should consider enhancing the current portfolio of transport standards to support consumer exchanges for Stage 3 Meaningful Use and they asked us specifically to look at the Blue Button Plus Project, the HL7's new Fast Healthcare Interoperability Resources Initiative and the RESTful Health Exchange Project, each of which I will briefly describe and to try to identify industry trends and emerging standards from those efforts. They asked us to take the lead, the NWHIN Power Team to take the lead and to get reviews and comment, and recommendations from the Privacy and Security Workgroup and from the Consumer Technology Workgroup which we've done. Next slide, please.

When we presented our preliminary recommendations to you guys in June this committee expanded the scope of this project to go beyond consumer provider exchanges. I think the situation was that as you saw all the recommendations we were putting forth and indeed as we saw as we were putting them forth we all realized that there was nothing unique to consumer provider exchanges that warranted limiting these recommendations to just that use case. So, what we'll present today is our expanded recommendations to be applicable across all of – any type of healthcare exchange that can reasonably be supported using a RESTful service.

For those of you who may not be familiar with REST, REST itself is not a standard it's really a style of programming that uses the commonly understood web standards that we all use every day like URLs and HTTP to access services on the web and to exchange data. So, it's a way, it's a simpler way of accessing web services and exchanging data. Next slide, please.

Blue Button Plus is the current name of what Doug Fridsma has frequently talked to this committee about, it initially was called the Automated Blue Button, it's the next generation Blue Button to support – it's a set of standards that support exchanges between providers and consumers, and between providers and third parties that a consumer names to receive their health information.

There are two sides of, if you will, Blue Button Plus. There is the Blue Button Push, which is the provider pushing information to the consumer or to the third-party and the team has adopted the Direct Protocol for that for that push.

So, the more interesting one at this point is Blue Button Pull which is really a query type interface where a consumer or third-party actually queries an EHR and pulls data from the EHR. The Blue Button Plus Pull is currently underway but they have chosen to specify a RESTful exchange and they use the two other standards that we looked at, one called OAuth2 to authorize an application to query and pull data and FHIR, which is the HL7 standard that's being developed to query and retrieve selected EHR resources.

The Blue Button Plus, and this is really important for a later recommendation that we have, the Blue Button Plus includes a concept of a registry service that distinguishes two categories of registration, registration of an application. There is a trusted registration, which means that the App is registered with this registry service based on its ability to protect the token that it's given by OAuth2 service and the client secret that's exchanged between the server and the client. And then the second type of category or registration is called open registration which simply means that the application is not registered with the registry service. So, next slide, please.

The second initiative we reviewed is the FHIR, HL7 FHIR specification and this is a healthcare content standard that's being developed and it's used to support Blue Button Plus Pull and the pull, the query and retrieval that the pull does.

And then the third project we looked at or third initiative is the RESTful Health Exchange which is called RHEX, pronounced REX, Project. This project is jointly sponsored by the ONC and the Federal Health Architecture and it's really a project to develop worked examples of implementation of various standards and various use cases using RESTful services to support health information exchanges.

The RHEX Project uses OAuth2 to authorize applications to do things take actions, access assets and it uses OpenID, another standard called OpenID Connect to share identity attributes and I'll describe that a little bit further. The RHEX Project also uses an older standard called hData for content and they indicated to us, the project team indicated to us that they may be migrating to FHIR for the content. Next slide, please.

As you'll recall from the June presentation, as we looked at these projects we recognized that there were two levels of specifications here. They weren't all – it wasn't all apples it was sort of apples and oranges. There were a number of lower-level building blocks that were really commonly used together to create these higher-level use case specific applications.

W

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Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Beg your pardon? Oh, and the lower-level building blocks that we recognized were HTTPS, which is what – that's secure web, that's what you use to buy something on Amazon. OAuth2 is used for authorization of third-party applications and this is important, when we talk about authorization in many, many cases we're talking about authorizing users or authorizing roles to do particular things. In the case of OAuth2 we're authorizing an application or a mobile App to do a particular or take a particular action or access a particular asset. The third of these building blocks is OpenID Connect, which is a standard that allows the sharing of identities and attributes, and the fourth is FHIR, which is this simplified content.

The higher-level applications then use these lower-level building blocks to meet the needs of specific use cases. In the case of Blue Button Plus Pull they use these standards, it uses HTTPS, OAuth2 and FHIR in order for a customer or authorized third-party to query and retrieve health information. And RHEX uses HTTPS, OAuth2, OpenID Connect and in the future is likely to use FHIR as well. Next slide.

Oh, there's my animation. Next slide, please. Okay, I've briefly talked about OAuth2 and OpenID Connect, and FHIR but I'd like to go a little bit greater depth about both what they do, these standards do and where they are, what their current status is.

The OAuth2 is an Internet engineering taskforce standard for remote service and third-party authorization. It is a right – it's been published as a Request for Comment, which many, many Internet standards are RFCs or Request for Comment. It provides a flexible framework with a great deal of options to choose from that supports the authorization of an application to take particular actions. So, it does need to be profiled for specific use cases as in the case of Blue Button Plus Pull. It's a web standard so it uses HTTP and it assumes a browser. It's used by both the RHEX Project and Blue Button Plus Pull and right now it's a balloted standard that's widely used by the major Internet companies out there today, by Google, by Facebook, eBay, LinkedIn, they all use the OAuth2. Next one, please. Next slide.

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

Hi Dixie, can I just interrupt quickly, we're getting a little bit of feedback, so if everyone can please remember to mute their lines it would be appreciated. Thank you.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, can you hear me okay?

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

Yes.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

We hear you just fine.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, okay, thank you. The next one is OpenID Connect. Open ID Connect is developed by the OpenID Foundation and it's a less mature standard than OAuth2 it's for remote authentication. It communicates authenticated user information from one service to another such as what's done in single sign-on. So an individual or a program or a server authenticates itself to one service and then instead of having to authenticate again if it accesses a second service its attributes are passed on to that second service by the first service. So, it just makes for a cleaner movement from service to service.

It is similar to what in the SOAP-based architectures they use the SAML or Security Assertion Markup Language to pass the security attributes, but OpenID Connect is specifically for RESTful applications instead of SOAP-based applications. It is layered on top of OAuth2 so the two of them work very well together. And it is an emerging standard in limited but growing use and in this case it's used by the RHEX Project. Next slide, please.

And the FHIR is a new HL7 standard that's in development. It is strongly supported by HL7's leadership and they're assigning a lot of resources to FHIR for its development and it's gaining a lot of attention in our industry and a lot of support within our industry.

FHIR – there are two things that are really important to understand with FHIR, number one its emphasis is on simplicity and implementability and human readability. So it is designed from the outset to be a simple standard to use. And the essence of that simplicity is the fact that it focuses on resources. Everything is treated as a resource used for exchange.

It's licensed free of charge, which is something new for HL7 and right now the base specification was just published at the beginning of this month as a DSTU, Draft Standard for Trial Use, and HL7 is now defining resources using this base specification. In the projects that we looked at Blue Button Plus uses FHIR for the query and retrieval of selected resources, content resources. Okay, next slide, please.

Now this one has some animation so I'm going to have watch carefully. What you have there before you have, it's basically the same story that I told you in June but I tried to make it a little bit clearer that we're really talking about three different domains. There is a customer who is accessing an App on their mobile device or their tablet, or their laptop and that App is then exchanging data and methods with a service that exists on a server somewhere, perhaps in a cloud, that is operated by a third-party. And then at the bottom you have the provider which is the holder of the EHR data.

Okay, would you do the animation, please? The first thing in this scenario is the consumer uses the MyHealthMonitor App to record her diet and exercise, blood pressure, etcetera and she identifies the provider who holds her EHR data. The data that she enters into that App are pushed out to MyHealthMonitor service. Next, please.

Okay, the MyHealthMonitor service then authenticates itself to the provider's EHR service and asks for the consumer's data. Then, next slide, the EHR service then authenticates the consumer, makes sure that that consumer has an account with its portal, it's consumer portal and it asks the consumer, it reaches out to the consumer on whatever device they are using and says should I allow MyHealthMonitor to access your EHR service? And then if the consumer comes back and says okay then the next step, please, then the MyHealthMonitor from that point on the MyHealthMonitor server can then use FHIR to query and pull EHR data objects from the individual's EHR.

So you can see here the dotted lines are all secure REST, secure web, secure HTTP and the OAuth is what enables that asking of the consumer do you want to allow this action to occur to happen. And FHIR provides the language for the server to query for a specific content object. Next slide, please.

And this is how Blue Button Plus works. So, this is the readiness assessment that we presented in June. What you see in red are the base building block standards and the perceived our assessed maturity of those standards and what you see in the white boxes are the two projects that we looked at Blue Button Plus Pull and RHEX. And as you can see the OpenID Connect is the least mature and the most mature by far is HTTPS and OAuth2 is certainly on the cusp to qualifying as a national standard. Next slide, please.

So, our initial overarching conclusion was that you could use secure RESTful transport with OpenID Connect, with OAuth 2 for authorization and with FHIR for healthcare content to represent healthcare content to query and access resources to create, together, to create a safe and appropriate application that meets the needs of a particular use case. Next slide, please.

Okay, the Power Team presented these concepts and our conclusions to the Privacy and Security Workgroup and the Consumer Technology Workgroup and I'm going to report now what we learned from them. Next slide.

The Privacy and Security Workgroup had several members who had direct experience with these standards so that was very helpful. They had actually used them in developments and so that was very useful. They ended up recommending – making one recommendation and that is that we add an IHE profile to our recommendation.

One of the projects that some of the Privacy and Security Workgroup members had worked on is this development of the Internet user authorization profile, it's an IHE profile that uses these NwHIN recommended standards to address use cases where a resource service needs to make additional access control decisions beyond the one that I just told you that OAuth2 allows to be made, shall I allow this access to happen yes/no?

And some of the examples that they used in the development of IUA are is the data segmentation for privacy use case, the emergency break the glass override, role-based enforcement these are richer access control decisions, they are sort of multilevel access control decisions.

The IUA uses the JSON web tokens to authorize access and JSON is JavaScript Object Notation which is JSON web tokens or JWT and it optionally uses SAML tokens to exchange user context attributes that we talked about earlier. I've authenticated this individual or this service and I'm passing them onto you, the attributes onto you. The status of this is that IUA is right now a draft for public comment that was published in June of 2013 of this year, last month or the month before last. Okay, next slide, please.

When we presented this to the Consumer Technology Workgroup they made an observation and that is that because OAuth2 depends on the portal, the identity, the portal identity of the user, remember in the picture I showed you that the EHR service authenticates the identity of the consumer using their portal identification and so Blue Button Plus Pull and OAuth2. Blue Button Plus Pull does a redirect to this patient authentication service through the portal authentication.

So, because that dependency exists the Consumer Workgroup wanted to point out that it's very, very important that providers make sure that the level of assurance that's provided by that portal identity management approach, whatever it happens to be, is sufficiently robust and by that we mean how their identity is assured to begin with, they give them an account and how they are authenticated. Both of those two are important to pay attention to. Next slide, please.

Okay, moving on to our final conclusions. Next slide, please. In these conclusions you'll note that some of the text is in bold and the bolded text indicates the recommendations and the rest are observations and comments that we made.

We still hold that secured RESTful transport , OpenID Connect, OAuth 2 and FHIR can be used together to be safe health care application and we recommend that **ONC support the development and piloting of these standards as candidate building blocks for healthcare applications.** Harkening back to the readiness graphic that I showed you earlier and I'll show you in a minute, you know, not all of these are fully mature at the present time so they need **ONC to support their further development and their piloting.**

Looking at the two projects we looked at, we felt that the Blue Button Plus Pull actually holds potential to become a national implementation specification in future Meaningful Use additions, but further development and piloting are needed before it's ready for that. The RHEX Project is more of a useful demonstration of how these standards are used together and so there may be specific profiles that come out of the RHEX Project but it's doubtful that the RHEX Project itself would ever become a single implementation guide. Next slide.

The IHE IUA Internet User Authorization profile appropriately constrains and structures OAuth2 to support the sharing of user context assertion such as these attributes needed for secondary authorization such as purpose for use and data segmentations for privacy, break the glass, etcetera and so we are recommending that IHE IUA profile be considered for use in those environments that require coexistence with existing profiles that are based on the IHE constrained user context assertions. So, if they already are using these types of assertions that can be passed and these types of complex authorizations – and if they have these kinds of complex authorization needs the developers should consider using that IHE IAU profile.

The Blue Button Plus concept of registry service, which I described earlier, they recognize the trusted registration and open registration. That concept assumes a policy that has not been established. It assumes that there is a need for – that any Apps that are authorized to access an EHR need to meet certain criteria of trustiness, but this policy hasn't been established.

And also an additional concern is that calling one of these "trusted" and one of them "open" implies a level of trustworthiness that may not be justified because that trustiness right now is just dependent on the ability to protect the token and the shared secret.

So, we recommend that ONC ask the Privacy and Security Tiger Team to address these questions of number one, whether trusted registration with a registry service should be required for Blue Button Plus Pull and secondly, if so what should trusted entail? Next slide, please.

This is our updated readiness assessment. The only change we made is the addition of the IHE IUA profile. IUA is based on OAuth2 but it is a new profile so we assessed its readiness. It's being piloted now. Next slide, please.

And this is our revised recommendation. It is the same as you saw in June with the addition of the use of the IUA profile as applicable. Okay, that's it the only other slide is a list of acronyms.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Dixie, great, thanks very much and of course Wes Rishel's card is up so we'll get to you Wes in just a second, but Jon Perlin sort of a matter of just process here which is have a set of recommendations from the NWHIN Group and in effect we were asked to evaluate these standards, consider their maturity, to ask if maybe they'd be appropriate as we look forward to transport in Stage 3. So, although our agenda did not specifically seek us to make a sort of formal acceptance of these recommendations, I presume as a process step after discussion that we should say, okay, committee do you see that these are sort of reasonable, well thought out and therefore we will hand them off to ONC as we deliberate on Stage 3 transport standards or something to that effect?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thanks, John, I believe that makes a good deal of sense. This is essentially closing the loop from our earlier conversation where we indicated that that was the desire to go in that direction. I know that Jamie Ferguson has offered a card and off line look forward to his comments on one, but with input from the committee that would be a terrific outcome to help provide ONC some directional information.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very good, well –

Jamie Ferguson – Institute for Health Policy/Kaiser Permanente

And this is Jamie Ferguson –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

John, I think before we get to the Q&A and comments from the team, I neglected to ask my Co-Chair if he had anything to add and I would like you to give him the opportunity to say anything more to clarify anything that I may have not communicated clearly.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Sure, so why don't we go with Dave McCallie and then it sounded like there was a related comment from Jamie and then we'll go to Wes.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

Dixie, you should know me better I would have spoken up if I had anything that I disagreed with. You covered it well. Thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, well, Jamie, your comment?

Jamie Ferguson – Institute for Health Policy/Kaiser Permanente

Yeah, so, I guess first of all I'm extremely supportive of the recommendation for ONC supporting development and piloting and of course I'm, as you may know, wildly supportive of the future use of FHIR. However, I do have to note that there are some statements and assertions here that I think are too optimistic and I think in particular the use of these standards together to build safe healthcare applications is, I think, a wildly optimistic assertion that has no evidentiary support at this time.

So, I think the purpose of the piloting and development is to build that base of evidence so that we can move forward with these. But I would note I don't believe that there has been any documented pilot for example of FHIR that would give us any evidence for this base. And, you know, it sounds like I'm being negative on that, but I'm actually one of the biggest supporters of moving in the FHIR direction. I just think that it's not there yet. That's my comment.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

That's a really good comment Jamie. I think that we should indeed soften that statement because we really haven't proven – yeah, we probably should change “can” to “may.”

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

But, this is David, I'll just make a little bit of clarification that FHIR itself doesn't address security so you put the focus on safe and I didn't know, Jamie, if you were talking about clinically safe or –

Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy - Kaiser Permanente

Yeah, I was thinking about – I was in fact thinking about patient safety.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

Okay.

Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy - Kaiser Permanente

Right.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

So, I mean, one of the things that we appreciate about the FHIR approach is that it heavily leverages a lot of existing HL7 knowledge and experience just packaging it in simplified and cleaner ways so it isn't as much of a start from scratch as it might appear to be to someone coming to it from the outside. So it does, you know, hopefully, carry forward lots of powerful learning from the V2 and V3 experience and I think that makes us maybe a little bit more optimistic than we might be if it was a brand-new start from scratch effort.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, I think that, you know, I think looking at our final recommendation, I think that we might just delete the “safe and” and just make it an appropriate set of standards, because Jamie is right we haven't done anything with respect to – I mean, not only have we not done anything with respect to safety and overall security, but both of those attributes would be implementation specific. So, that would be an overstatement without the context around it.

Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy - Kaiser Permanente

Yeah and so I think if the – you know, if the recommendation is a strong recommendation to pursue piloting demonstration projects and evaluation of them in order to move this body of work forward to me that would be really valuable.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, thank you, very much. So, Wes Rishel?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Thank you, John. So, Dixie can you go back to the slide where you talked about level of assurance?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

While you're doing that I will pile onto this discussion we just had. And I recognize there are some ambiguities that have to be dealt with there, but in addition to recommending the necessary piloting to assure, particularly, I don't know how to say it, avoiding errors of ambiguity in using FHIR to exchange clinical data, whatever the safety issue is, the patient's safety issue is, I think it's important to put a deadline on that or urge that ONC consider a deadline specifically such that it could be considered for Stage 3 Meaningful Use measures or objectives, or whatever the right term is.

That is I think there is a lot of enthusiasm for FHIR right now, which in Gartner terms we call "the peak of the hype cycle" and there is inevitably a – the pendulum swings the other way again and then real practical use begins and I think that since we know that we're going to go through that cycle let's try to do everything we can to be through that cycle in time to be able to make a crisp decision for Stage 3.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Wes, this is Dixie, which slide did you want? Did you want the graphic or the one that talked about Blue Button Plus assurance?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I want – you know, the problem was I wasn't actually looking at your copy of the slides when you made the statement, but let's go – no it would have been back towards the scenario I think where you made this comment. At some point you said that the two committees that you reviewed this with expressed a concern that the other applications that work with provider applications must have the same level of assurance that provider applications have –

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Oh, no, no I definitely did not intend to say anything of that sort. I think you're talking about the Blue Button, the observation of the consumer where it was dependent on the authentication of the user through the portal?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, that would be, let me see, that's slide 16. Go forward, yeah exactly. Good, thank you. Yeah and I definitely didn't say that the level of assurance of the authentication needs to be equivalent to anything. There is no implication of equivalents.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, okay, well, I, as you know, because I'm not known for hiding my concerns under a bushel, my concern is almost the opposite.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

That we have right now a robust growing set of Apps that consumers use on their own with virtually no level of assurance of the identity of the consumer. There is a level of assurance of consistency of the identity of the consumer, that is to say, I might be Charles Atlas 23 on MyNetDiary and I might be Foxy Lady 12 on the Withings Electronic Scale, but because I made the link between those two using the authentication associated with those user IDs it's perfectly acceptable to exchange that data.

And likewise, if we were to bring my provider's electronic health record into the loop and I used the credentials that the provider gives me along with the credentials for MyNetDiary, which is a food monitoring application, that's all that's needed. There is no need for the people who built this cloud-based App who never get within, you know, 10,000 miles of their consumers to do a driver's license check or somehow find out what my real name is or anything like that.

And if we put those kinds of restrictions on consumer-based Apps we are just of slowing down the ability for the activities that are going on in an innovative way in the private market to work together with the applications that we're more used to, which are ones used by healthcare providers.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yeah, we did –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie, can I make a comment on that?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

May I reply to him please?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Go ahead.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Would you please go to the graphic of the whole Blue Button Plus Pull, that one, and just go ahead and build the whole thing. Wes, I'm glad you asked this question because it really is important that everybody understand this.

The EHR service is authenticating the consumer who will be giving them the authorization. It's very important that they know that that EHR service know who is saying, yeah, let this App access my data that's very important. But that authentication is not even shared with the App itself it's just authenticating the consumer before they give the authorization.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

No, I think those of us that have been – first of all, maybe we should let Leslie comment and then I'll come back.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right, so in the interest of time if we can just take the comment from Leslie, quickly wrap up this discussion and Arien Malec also has a comment and then we should turn it over to ONC. So, Leslie?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

Super, thanks, I think that the emphasis in our recommendation is the referring to the provider for their application, for their services they are providing that there is a good level of assurance because today the provider's risk when we think of Blue Button is very minimal they're just sending something out to an individual e-mail address, a Direct address or wherever the patient sends and the level of risk is very low and probably the leverage of assurance or process included in that is representative of that risk.

When we start attaching Apps to it we're just simply suggesting that the provider best practice when they initiate that first LOA, which is between them and their patient's portal and their patient it's establishing that first account that it has good, robust measures and processes to confirm and attach that patient because that becomes a binding effort.

And then as the patient attaches new things to that application it really not only makes it clearly the patient responsibility, but the provider has done all reasonable efforts to make sure their initial authentication, initial level of assurance of that patient account is sound.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, I certainly don't disagree with that statement except to note that whether or not there is a third-party application the provider has the same requirement in terms of level of assurance for providing access to the portal there is no additional requirement because there is another App involved. But I am concerned that we not create a recommendation here that is used to support the concept that we have to begin a lot of regulatory efforts on these consumer-based applications that are out there.

I am in danger of having people confusing me with a Republican here, but I think we want the free market to act very aggressively in terms of finding new models for how to engage patients and we don't want to be restricting that.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, well thanks.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I think the comment, Wes, has more to do with the – is more relevant to our recommendation that the Tiger Team take up the questions around the registry service. That's exactly where your comment is really well directed.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

And, hopefully, ONC will follow our advice and the Tiger Team can directly address what you're talking about, which I agree is a very important point.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thanks, well Arien Malec if you could make your comments and then we'll turn it over the ONC.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, hopefully should be quick. First of all I just want to point out, especially as we transition over to ONC that there a couple of S&I Framework Initiatives that would be ideal for doing these pilots and in particular there is one that has just kicked off that is the data access framework initiative and I know that FHIR is already being considered as work there.

The second comment is that oftentimes, and FHIR is in this boat, oftentimes there is a need for additional funding for HL7 and other standards development organizations and I would hope that as part of these recommendations we could also ask ONC to look for ways to increase both the amount of piloting and the amount of clinical testing and rigor that go into FHIR so that we can address some of the patient safety-related concerns and accelerate the overall work.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you. So, I think what we have, as Jon Perlin and I had introduced, is a body of work that has been created by this Workgroup and our hope is to transfer it to ONC with the support, consensus support of the group recognizing we wish pilots to go forward to ensure that it is appropriate to incorporate such technologies into future stages of Meaningful Use.

So, as we have asked before are there any objections to forwarding this body of work to ONC with the understanding that pilots should be done expeditiously and that this will all inform our future efforts as we deliberate on very specifics of Meaningful Use Stage 3 and beyond? So, no objections being heard we will forward Dixie's report and of course we'll work on the appropriate ONC folks to craft the letter. So, hey, Jon Perlin turning it back to you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, let me turn it directly to Lauren Thompson, Mera Choi and Jodi Daniel for the ONC update and appreciate, I know ONC appreciated the last bit of very thoughtful input from the entire committee thanks to all. And thanks Dixie and David for your terrific leadership. So, without further ado we'll let the ONC team decide who is going to start.

Lauren Thompson, PhD – Director, Federal Health Architecture – Office of the National Coordinator for Health Information Technology

This is Lauren and I think I'll be starting. If we could go onto the next slide. So, thank you for having me here today, Doug was not able to join so I'll be giving you an overview of where we are on the S&I Initiatives just highlighting a couple, Mera Choi who is the S&I coordinator is also on the call. So, moving onto the next slide.

You've seen this slide before, just some of the current metrics as of the beginning of August. We've been operating for about 31 months now and continue to be very, very active. We have, looking over to the right, 19 consensus approved use cases, 36 pilots committed, 42 pilot vendors, 14 total ballots and as you can see a large number of ballot comments received and resolved. So, I think as we go through some of the initiative highlights you'll see a lot of the activity and of course we have the HL7 meeting upcoming in September. So, moving onto the next.

I'm just going to touch on the highlights of some of these, some of the more active ones right now. I'll make a few comments about the transitions of care. We have the companion guide, the project scope statement and the notification of intent to ballot completed for the September ballot and we're currently monitoring the Structured Documents Workgroups to ensure any updates to the C-CDA and the September ballot are accounted for.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator
Lauren?

Lauren Thompson, PhD – Director, Federal Health Architecture – Office of the National Coordinator for Health Information Technology

Yes?

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

So, this is Farzad, as you go through these if you could just note for folks where there has been a change in the status of the project since the last time this was presented if you are able to do that on the fly.

Lauren Thompson, PhD – Director, Federal Health Architecture – Office of the National Coordinator for Health Information Technology

Okay and Mera you can help me with that if you're able to. Data segmentation for privacy, I think this is one that has been ongoing, probably not a lot of changes since the last update. We have five pilots ongoing this has transitioned to a community led effort. So right now the pilots and the SDO balloting are the main focus.

Public health reporting, in September there will be a little bit of a shift here. This is been in sort of a waiting stage. In September the PHRI will begin phase 2 with the call for new user stories. That will an analysis of the phase 1 user stories for reporting into the reference implementation framework. So, Mera anything in terms of what's happening in September to add to that?

Mera Choi – Acting Standards & Interoperability Coordinator, Office of Science & Technology – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

No, I think that was – I think you captured most of that for public health reporting.

Lauren Thompson, PhD – Director, Federal Health Architecture – Office of the National Coordinator for Health Information Technology

Okay. If we could go to the next slide. Longitudinal coordination of care, there's quite a bit of activity here. We've completed the interoperable care plan exchange use case and consensus for that was achieved at the end of July, July 24th, revising the C-CDA to support transitions of care and the care plan exchange for the HL7 ballot cycle coming up.

We've developed and submitted recommendations to align the care plan exchange efforts with various HL7 Workgroups, including the Patient Care Workgroup, the – Care Coordination Services Workgroup. So, again, monitoring the CCD updates for the September ballot. And also looking and identifying potential pilots for the transitions of care and care plan implementations guide right now.

A couple of notes on Health eDecisions, currently three work streams ongoing, work stream one is the HL7 ballot for use case one and we are finalizing the implementation guide based upon the pilot feedback and those will be published shortly. Work stream two are the pilots and all of the pilots for use case one are complete.

Work stream three is related to use case two. The project scope statement and notification of intent to ballot will be going to ballot for the HL7 meeting in September. The two implementation guides that have been developed are for decision support service and virtual medical record template IG which specifies the vMR data elements to use in scenarios along with the value restrictions. And the final ballot materials for the DSS update were submitted to HL7 on August 4th.

Blue Button Plus, we heard a little bit about that in Dixie's presentation. The focus here is on adoption for vendors, providers and payers and supporting the current referenced implementation.

Structured data capture, I know there is a lot of interest in this. We have push and pull IDs are complete and now focusing on adoption and implementation. Two implementation guides are targeted for development based upon the REST, OAuth, SOAP, SAML. There are two technical work streams that are working a Forms Workgroup, Sub-Workgroup that was kicked off in June. This effort is being led by AHRQ and NLM. And there is a Standards Workgroup, Sub-Workgroup that was kicked off in early July. So, the next steps here are to come to community agreement on the full solution plan for the initiative and then to begin development of the IGs.

A new one that has been initiated, it was launched on June 20th is the European Union/US eHealth Cooperation Initiative. Doug Fridsma and Mera are leading this for the US. Presently we're supporting two work streams one around workforce development and one around interoperability. So, we're beginning the community meetings for these work streams presently.

And then data access framework, thank you Arien for your comments in regards to this, this was launched in July. And we've started the use case work in mid-August. So, this is focused on data access, local data access, meaning a standardized way for providers to access their own patient's data within a health organization's internal EHR system and then targeted data access, meaning a standardized way for providers to access a known individual patient's data in an external organization.

The first community meeting was held on July 24th and we drew the project charter there. The local data access work stream was the first to launch and is developing the use case now and we'll hopefully complete that by September. The targeted data access work stream will begin development of the use case in the October/November timeframe. So, we're currently reviewing possible scenarios and user stories for both use cases. So, those are some of the highlights of what's happening right now. Mera, do you want to add anything to that?

Mera Choi – Acting Standards & Interoperability Coordinator, Office of Science & Technology – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

I think you have captured most of the work. I just wanted to say that longitudinal coordination of care has also launched a Post-Acute Care Setting Workgroup.

Lauren Thompson, PhD – Director, Federal Health Architecture – Office of the National Coordinator for Health Information Technology

Okay. So, if you could go to the next slide, this is just a picture of where the pilots are geographically dispersed across the nation and if you, on the S&I pilot website if you would like additional information on any of these pilots you can go to the site and click on the map there and get the detail on those, but you can see there is good, pretty good dispersion of pilots across the country.

And just going onto the next slide, again, here are some of the links that you're probably very familiar with and would point you to those for additional information and certainly available for any questions or comments. Thank you.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

This is Farzad –

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

The floor is open for anyone who would like to weigh in.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

This is Farzad, if I may also – it would be, I think, particularly interesting would be hearing from the Standards Committee members in terms of whether there are some of these projects that you think are not priority development implementation consensus. And if there are others that you think should be here that you don't see listed.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

This is Arien, I'd like to be placed in the queue for that one.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Arien, please go ahead.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

And that's – thanks, Farzad for introducing the topic and in many ways I think this might be too big a topic for a brief comment. I would note that when I coordinated the S&I Framework one of my objectives was to keep the number of projects small and to have at least clear, plausible line of sight to Stage 2 Meaningful Use and one of the net effects was that if the people affected by Stage 2 Meaningful Use weren't participating in the projects they at least knew that the projects existed. And if the projects ended up in places that that they didn't agree with they had only themselves to blame for not engaging and participating and they had some skin in the game in terms of the outcome of the project.

And one of the issues that I see right now with the S&I Framework from the other side as an affected vendor is I literally don't know which projects to invest my time and energy in and which to frankly ignore. I'm putting a lot of time into the data access framework and earlier spent some time in Blue Button Push because of a personal belief that those were important, but I don't have a line of sight in the S&I projects to some plausible end state with regard to Stage 3 Meaningful Use and certification criteria. And so, my criteria is one of interest but not necessarily one of knowing what matters or having an engagement, a business engagement in the outcome.

So, my request would be, number one, if possible to narrow the field. And, number two, to the extent possible and feasible by regulatory constraints a better roadmap or indication as to where these are going so that people in the field can make better decisions about which ones to go after and which ones not to go after.

And a subsidiary comment to that one is that in cases where the vendor field or the provider field ignores the project there is a huge risk that the project will get into a state of unimplementability and I worry about data segmentation for privacy. We haven't done a detailed review of it, but based on what I know of it, I worry that we're in a state where the workflow that is implied by data segmentation for privacy is incompatible with HIT and with real work provider-based workflow and again, I think that's a function of you had a set of interested parties in that initiative who were interested, for all the right reasons for passion, but we lacked the people who were interested because we're going to have to implement it and make it happen in the real world. So, thanks for the opportunity to express my comments.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

This is David, I'd like to queue up as well.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Please, David, go ahead.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

I basically just would endorse what Arien just said. I think the vendors are distracted with many, many things to worry about and an ability to get a little bit better clue about which of these many S&I Framework projects is likely to result in something that actually makes it through to MU3 and certification would be obviously valuable.

My opinions are probably pretty similar in terms of specific projects. I likewise share the concern that the data segmentation for privacy, albeit addressing an important problem, is doing so in a way that would result in workflow that will be extremely cumbersome for providers to deal with.

I am a little worried about the Health eDecisions reviewing the results of the first pilot. The goal of sort of downloading compile seems to have been abandoned as infeasible in which case, you know, what have we achieved with that? I'm not sure we're advancing the state-of-the-art very much there. So I just have some deep concerns about that one.

On the other hand, the data access framework to the degree that it focuses on FHIR, as per our earlier conversations, seems like something to push forward on, keeping the scope as narrow as possible addressing, you know, real problems that we all acknowledge exist. I also like the Blue Button Pull as a kind of fundamental capability that makes a lot of sense to be pushed forward. Those are my opinions, obviously, but that's what you ask for.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

This is Farzad –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

This is Leslie, I have a comment too when you're ready.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

If I may –

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Go ahead Farzad then we'll go to Leslie.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Sure, I guess one of the things that this is raising up for me is that there is certainly involvement from the community and the Policy Committee in identifying high-priority issues for S&I activity and usually at the end of the S&I process and in advance of rulemaking we then come to the Policy Committee for review of the product from the S&I activities as we've done and sometimes that goes well and other times it has gone less well where the participants – particularly when the participants in the S&I activities represent a less diverse viewpoint than the Standards Committee does and sometimes that happens where the issues of interest to a relatively narrow group and also the people who can take the time to participate in the S&I. And when it comes back to the Standards Committee there is a mismatch and we've had to manage that mismatch at times.

And what I'm also hearing is an interest, although not an ability, on the part of different Standards Committee members to weigh in on the approach being taken by the S&I groups and the easy answer is if you disagree, David/Arien, well, you know, you've got to dial into the S&I Workgroup call, but I understand that you can't do that for every S&I initiative all the time.

So, I wonder if there are less about the specifics of the S&I activities but more about the process. If there are any suggestions folks have about increasing the connection and the kind of ground truthing, because it very well may be that you're wrong and they're right, right? They're the ones who've been spending the most time on this obviously and maybe do represent the community. But making sure that there is a better ongoing connection, any suggestions about how to accomplish that and I also throw it back to Lauren if you have ideas?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

And Farzad that was the intent behind my narrow the field and clear line of sight that, you know, fewer eggs and more eyes on the basket would be my recommendation.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Although just recognizing, Arien, the risk there is that that the national progress on pushing forward key interoperability standards is limited by the ability of, you know, a very small number of people to engage in projects. So, I think it would – there is a potential problem of saying we can't make advance on something that is really, really important because every single person needs to be involved in – or visibility on every single project, which I don't think is necessarily appropriate either.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

Farzad, this is David let me respond as well. First off I think it's a great question and we've had a few debates about it in previous Standards Committee meetings with Doug and I don't think we've ever hit on a perfect answer. But, I would look at it and say that, you know, from the vendor perspective given that we're all pretty busy, you can get our attention because it's something that we have to do or you can get our attention because we're excited that it creates new opportunities and solves real problems. But it's hard to get our attention if it doesn't fall into one of those categories.

So, it seems to me there is a little bit of a burden on the S&I Project itself to find a way to make itself attractive to the broader vendor community. And if they're doing something that fits into one of those categories the vendor communities will find a way to pay attention. Otherwise, they just will prioritize it down and it may not get the attention, you know, to engage with an S&I Project is a very time-consuming process and it's going to be metered out based on, you know, the perceived value of the project.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

And this is Leslie, to that point I think sometimes we don't know what problem it's trying to solve and is the problem that that particular group is trying to solve something that came out of policy, something that came out of standards or something that came someplace else and is there a higher degree of agreement that the problem is worth solving and doesn't need to be solved now I think would be important.

I also would also like to reinforce David's comments on the segmentation for privacy work, you know, it sounds really wonderful but very difficult to implement and then ask to what end. As a patient we can't predetermine the need of information to provide us the best and optimal care and I think HIPAA gives us so much protection about the misuse of data. But it doesn't give direction on how do you filter and predetermine need of data, we can't.

And so, I'm concerned about the unintended consequences by both the implementation of that and the lack of understanding of what it means to provide good care and have access to information to provide good care. So, I would echo David's concern from both the consumer point-of-view and the provider and vendor point-of-view. Thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And so Leslie's comment is very well taken as we implement the HIPAA Omnibus Rule and if patients self-pay privacy workflow restrictions in a real practice, Leslie, we're finding, let's see, so if they pay for this incident but at the next encounter if an insurance company – but it's a follow-up for the one they paid cash for, who can we send what to and do we data segmentation for privacy on every data element to include how did they pay for it, very, very challenging to implement.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

I will just for – just to make sure that we recognize the appropriate rules for our sister FACA, in terms of Leslie the issue of is this an appropriate issue policy aim? I think much of that needs to come from the Health IT Policy Committee and so I wouldn't – though there are many folks on the Standards Committee who are well qualified to weigh in on the policy issues as well, I would ask that for the purposes of feedback to the S&I initiative we take as a given or I think we explain and we help people understand clearly and be more transparent about why it matters and why it was, you know, why it was chartered.

But, I think, you know, issues of implementation needs and maturity, and so forth are perfectly appropriate. But it's a little, I think, overstepping, if I may say that, for the Standards Committee to say, you know, is this an appropriate policy?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

I wasn't implying that Farzad as much as the degree of how implementation and the rigor, severity and complexity of the implementation certainly gets to – does inform quality.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Yes.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

Yes.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise

And if we have overstepped bounds in terms of rigor or made implementation so difficult through the overuse and overzealousness of standards we haven't done our job.

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Right, I understand, that's in scope.

David McCallie, Jr., MD – Vice President, Medical Informatics – Cerner Corporation

And you asked about the projects themselves, which don't require Standards Committee endorsement, you asked whether the projects are worthwhile and how to get better participation I think some of us are answering on wearing the hat of should we participate or not, not on our Standards Committee hat. I mean, it may be a policy goal but it may not be very good. It may not be done well. It may not be appropriately implemented and that's not a Standards Committee question per se that is the framework going to get vendor and community participation and generate something worthwhile or not?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

This is Wes.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Fire away Wes, why don't we take this as probably a short and the last comment as we go to public input on this and I would just note as we go into that is that this one of the areas that we've tread cautiously on through our history as a committee. We've over the year's established better working processes with the Policy Committee and there is an inevitable interactivity between policy and standards and there is a different scope of purview, certainly and then there is a set of recommendations about practicality as Dave McCallie just mentioned that makes it work. And this is a great discussion about the interaction of those elements. Wes, please go ahead.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Some of us are old enough to remember a book called The Soul of a New Machine.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Yeah, Tracy Kidder.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Which took the – normally thought of as drive process of creating a new processor, a central processor into the realm of exciting humanistic literature and the point of it was that in reality it wasn't how good the technical work was it was whether it got out the door of a large bureaucratic organization because so much work goes along fine and then somehow doesn't make it out the door.

And I would say there's a similar challenge for the leadership of the individual S&I Framework Workgroups, because we do have checks and balances. We do have anything that comes out of S&I that's headed towards regulation does go through the Standards Committee, the Policy Committee, it goes through the regulatory process, goes through the comments on the NPRM and then finally does or doesn't get out the door.

And when you have someone leading an unbalanced effort they take the strong risk of getting a – you know, you get three people in a room all of whom, you know, vote for the same people and, sure, you get agreement but it doesn't necessarily get out the door. So, to a certain extent, given that there are checks and balances in place, I would argue that it's incumbent on the leadership of those Workgroups to make sure to recruit, to advertise, to threaten, cajole, to do whatever to get a fully balanced spectrum of views into the work they do.

Lauren Thompson, PhD – Director, Federal Health Architecture – Office of the National Coordinator for Health Information Technology

And, this is Lauren if I could respond to that for a moment. We do, within each initiative, do quite a bit about reach to the community with the intent of trying to touch those who we feel we do need to participate. So, we do quite a bit of outreach when an initiative is kicked off and throughout the process.

I also wanted to make a comment about the request for a roadmap. We actually are in the process of putting that together. So, I think it might be helpful at an upcoming meeting to bring that to you and share that with you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, Lauren. Well, that seems to be a good place – I think there's a consensus around really the active discussion of work in process and the pragmatism as well as purview and I think that's a theme that will obviously punctuate not only the interrelationships between the Working Groups but the relationship with ONC and its activities. Tremendous thanks are due to all of those who worked in preparation for today's Workgroup updates and certainly to ONC for ONC's hard work in all of these activities. Before we go to the public comment period, want to turn back to Farzad for any comments.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Jon?

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

Actually, Jon, this is Michelle, I'm sorry Jodi Daniel actually has an update from the Policy Committee before we close out.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

I'm sorry, I jumped ahead. Let's do that. I want to make sure do get the public comment period in.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Okay, well, let me see maybe I'll kind of go through this quickly and not touch on everything in detail and let you all kind of look at the material yourself. So, why don't you go ahead two slides. Okay, first I just wanted to let folks know that ONC is hosting the third annual Consumer Health IT Summit in Washington DC September 16th.

The goal is really to learn about and be part of a public/private sector about advancements to equip and empower patients to better manage their health in a digital era and we will be having some examples of Blue Button implementation, some discussions about recent and upcoming policy, changes to champion rights and their ability to access their health data and some innovative Apps to address consumer needs. So, there is a link here you can check it out and learn more. Next slide.

So, I wanted to let folks know that on August 7th CMS and ONC released and held a webinar to discuss what we're doing to enable HIE across the entire healthcare system. We launched a new page on healthit.gov to highlight some HHS activities to accelerate HIE. This was in response to an RFI that we had put out a while back and got a lot of public feedback on how we can use the different levers that HHS has to accelerate HIE. There is lots – again, I'm going to go through this a little bit quickly.

There is lots of information on our website. We include some of the principles and strategies. We talk about new HHS regulations and guidance on existing programs to enable patient's health information to follow them whenever they access care, HHS's programs to advance HIE across providers including long-term and post-acute care, behavioral health and laboratory providers building upon and moving down the foundation of the Medicare and Medicaid EHR Incentive Programs and the ONC HIT Certification Program, lots of information. I'm going to direct you to the link here instead of walking through all of the details that are in there. But there is a lot of – it's a good read if you have not looked at what we've put out on the website on this. Next slide.

Again, quickly I want to let folks know that ONC released a progress report on the implementation of our Federal Health IT Strategic Plan that we put out that covers 2011 to 2015. It highlights resource and services the federal government implemented to guide nationwide adoption and use of HIT. We do plan to update the progress report in early 2014 and we also do intend to update our strategic plan. As you can tell we are part way through. There has been a lot of change and we want to have our plan reflect the latest thinking on our Health IT strategy across the federal government. So, stay tuned. Next slide, please.

So, ONC, CMS and NIST jointly released an approach to testing interoperability among Stage 2 certified EHR vendors. So, this is specifically to address the MU2 Stage 2 transitions of care measure number three. So, for this providers have two options under this measure. We expect that most will meet this measure by the first criteria of exchanging a summary care record with another provider that has a different EHR. However, we expect that there will be some circumstances where providers meet this measure by the second criteria, which is exchanging whether CMS does in a test EHR and this demo addresses that second option.

We've posted several documents outlining how providers can use the testing infrastructure and how vendors can participate in the program and we intend to launch a pilot with 5-7 vendors in September and make it operational in alignment with the timeframe for eligible hospitals. Next slide, please.

Briefly, just wanted to let folks know that we've recently released a number of resources available for providers who are working to achieve Meaningful Use this includes tools and ideas for solutions to some Meaningful Use challenges, information on success stories and case studies for implementing EHRs and all of the information, again, is available on healthit.gov. So, there are some specific links to help folks find some of this material if you're interested. Next slide.

Briefly, as part of our work on Health IT safety, we released a guide for EHR contracts focusing on key contract terms for users to understand, it's really targeting the providers that will be entering into contracts with vendors and it's helping the purchasers and users of the EHR system who may not be aware of some of the terms that may be in standard vendor contracts to understand, provide some plain language explanation to assist them in evaluating those contract terms as they are entering into those agreements. Next slide.

This is where I want to spend most of my time that's why I rushed through some of those others so that we have time for public comment. So, I wanted to give some updates on our Health IT Policy Committee. We had a meeting just earlier this month and there was a lot of good uptakes to talk through, Meaningful Use Stage 3, FDASIA, Privacy and Security and Information Exchange. I'll talk to each one of these but briefly.

With respect to Meaningful Use the Workgroup presented its draft recommendations and some of the Policy Committee members sought clarification on the focus and the underlying framework used in developing the recommendations. So, there is currently some work going on with the Meaningful Use Workgroup to make revisions. The Workgroup agreed to revise the draft recommendations and present an updated version of the September 4th meeting, so this is a stayed tuned.

We expect the revised recommendations will align with each top line MU3 recommendation, but focus on the health or care outcomes to be achieved by the recommendation so looking more at the outcomes that kind of underlie some of the details of the discussions that they've been having.

The revised recommendations will also identify some eQMs as an important tool to measure the outcome success and highlight functional deeming as an area worthy of additional exploration. And the Workgroup plans to provide some additional detailed recommendations as needed later in the fall. So, again, I encourage folks to pay attention to the September meeting, although I will bring back recommendations from that meeting to this group in our September meeting of the Standards Committee.

With respect to FDASIA, as a reminder, we had a Workgroup, the Workgroup was charged with providing expert input on issues and concepts identified by FDA, ONC and the FCC to inform the development of a draft report and appropriate risk-based regulatory framework related to Health IT that includes mobile medical Apps that does three things, promotes innovation, protects patient safety and avoids regulatory duplication.

They presented draft recommendations to the Policy Committee and there was a lot – it was actually a very dense and rich presentation which I could not give justice to in this discussion. They walked through a lot of issues such as that there is – that there – they've looked a lot at the existing regulatory regime and what ONC is currently doing, what FDA is currently doing, what FCC is currently doing and tried to scope some of what may need to happen in the areas where there is some ambiguity.

The recommendations were well received but the committee requested that the Workgroup provide some additional clarity. Some of the issues that wanted more clarity on were regarding the Health IT that would be subject to the risk-based regulatory framework, so, a little bit more clarity on the scope, providing more specifics on how the agencies can better coordinate, looking at interoperability as an area of focus and trial ability. So, how can the agencies enable small-scale trials of Health IT products without kind of kicking in a significant regulatory oversight scenario.

Just to briefly let folks know this will be – they will present final recommendations in September for the Policy Committee to consider. The three agencies will then go back and take that input and think through a draft framework for oversight of Health IT that promotes innovation, protects safety and avoids regulatory duplication, which can include – as well as private sector engagement as well and we will be putting that out. Our intent is to put that out in January of 2014. We will also have a comment period once we put that out. I want to let folks know that if you are interested in this work that there is a comment period that's open currently to give input to the agencies that closes on August 30th. So, we welcome folk's feedback.

I will briefly, Privacy and Security update, the Policy Committee made recommendations on two things. First, non-targeted query. They said that the existing recommendations on meaningful choice and targeted query are sufficient in addressing non-targeted queries and that no additional policy is needed at this time.

And the second was Meaningful Use attestation for security. The recommendation was that instead of selecting additional HIPAA security rule provisions for emphasis on Stage 3 that they recommend to improve accountability for complying with the existing Meaningful Use security measures in particular, the requirements for a security risk analysis and correct identified deficiencies.

And lastly with respect to Information Exchange, they made recommendations to the Policy Committee as well on provider directories. Two recommendations that were put forward, one was on search for provider. They recommended that EHR systems have the ability to query external provider directories to discover and consume addressing and security credential information to support directed and query exchange.

And second, respond to search that they recommended that EHR systems have the ability to expose a provider directory containing eligible professional and eligible hospital addressing and security credential information to query from external systems to support directed and query exchange.

And that was real quick, that was about a 20 minute presentation in 10. So, I will open up for any questions and understanding, Jon, I defer to you on our time situation and how to manage that. Thank you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thank you Jodi, that was a tour de force. There is a very rich amount of information. Let's taken any brief comments or clarifying questions and commit to coming back with any additional questions in our next meeting if necessary. But the floor is open for any questions or clarifications that the committee would like to seek. Well, Jodi –

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

I think I confused everyone by rushing through it.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Hi, this –

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Or it was just perfectly clear.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

This is Arien, I would love at a future meeting a more deeper dive on the FDASIA work.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

You know, I would be happy to do that and I think it will be better to do that after the recommendations come out in September. So, I will plan to devote a good amount of time to that.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Thank you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, other areas that committee members would like to hear more about?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Jon, this is John and of course as we get marching orders from the Policy Committee on things like provider directory query, pub-sub those various types of transactions that would allow an EHR to participate in query-based ecosystems we'll need to turn those into standards recommendations. So, we'll need further detail.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, we'll mark that as an upcoming agenda item as well. Okay, well, I want to be respectful of everyone's time and really appreciate your concentration. Jodi, sorry to shortchange you time-wise but thank you very much a tour de force in that. Lauren and Mera thank you very much for your presentations and input as well. Before we go to the public comment session, John Halamka anything that you would like to offer?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

No, just again, as you said thanks to everybody for hard work because today's presentations represent the culmination of months of hearings, calls and investigations. So, thank you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Absolutely and Farzad anything you'd like to offer?

Farzad Mostashari, MD, ScM – National Coordinator – Office of the National Coordinator

Nothing to add.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thank you again for your terrific vision and leadership and we look forward to working with you in all capacities immediate and after. Michelle, this concludes our formal agenda of presentations but of course, we move now to a critically important opportunity for public input. So, let me turn to you.

Public Comment

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

Thanks, Jon. Operator, can you please open the lines for public comment and as a reminder public comment is limited to three minutes.

Rebecca Armendariz – Project Coordinator – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-6006 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We do have a comment.

M

Our first comment is from Gary Dickinson.

Gary L. Dickinson – Director, Healthcare Standards – CentriHealth

From CentriHealth, Director of Healthcare Standards at CentriHealth. We have submitted a public comment a document via Jon and John to the Standards Committee. As many of you are aware we are extremely concerned about the use of the term interoperability in the context of Meaningful Use Stage 2 and we're also concerned of course that the interoperability definition that is used is the IEEE 1990 definition which talks about exchange which is technical interoperability and semantic interoperability which is use.

And we believe that if that definition were to be followed, that in fact, use implies very specifically fitness for use. And we believe that with the double transformation schemes required to take source data and transform that into an exchange artifact the Meaningful Use required document and messages that in fact – and then transform that again to the receiver’s internal format that there is actually two transformations that are occurring in that process.

And that if in fact the resulting data is different than the source data that, that in fact has the potential, the very strong potential and likelihood of introducing errors and omission in clinical content and thus we believe that the resulting information is not fit and cannot be reliably claimed to be fit for clinical use on the receiving side.

So, we put together an analysis page which goes through the very details of how that – of where the issues are and we would appreciate if the committee would take that up and give us any feedback that might be useful in terms of better understanding this particular issue and of course addressing the issues that are raised as well. Thank you.

Rebecca Armendariz – Project Coordinator – Altarum Institute

We have no further comment at this time.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thanks, Gary for that input, indeed that’s been submitted to Michelle Consolazio and into the FACA process and we appreciate very much that input. Our next Standards Committee meeting will in fact be in Washington on September 18th and let me turn to Michelle for any further detail on the meeting.

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

Unfortunately, as of now we don’t have further details. It will be an in person meeting in September. We are still confirming hotel location.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, terrific. All right, so all committee members can plan on travel to Washington. We have a couple of loops that were mentioned by Jodi Daniel and John Halamka to close in our next meeting and again, many thanks to everybody for your participation. Sorry we went a little bit over our scheduled time but appreciate greatly the robust discussion and input. We stand adjourned for today and look forward to seeing everybody in September.

Judy Murphy, RN, FACMI, FHIMSS, FAAN – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

Hey, Jonathan, if I might, Judy Murphy here, just real quick to put – and make sure everybody knows that that’s Health IT week and so there are other activities going on that week so you might want to look at that before you make your flight arrangements because you might want to come in for example on Monday is the Consumer Health IT Summit that Jodi talked about, so just to draw that correlation.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, I appreciate Judy you saying that. So, if we can ask that perhaps ONC could, as you post information about activities, perhaps committee members could just get a quick note with the schedule of activities.

Judy Murphy, RN, FACMI, FHIMSS, FAAN – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

That sounds great.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Terrific. Any other announcements? All right we stand adjourned. Many thanks to everybody.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel
Deaconess Medical Center**

Thank you.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you.

M

Thank you.

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

Thank you.

Public Comment Received During the Meeting

1. A most important role that government (ONC & CMS) in User-Centered Design (UCD) for EHRs is to give private industry (vendors) enough time to react to the final rule for a proper SDLC, including user testing, feedback of the programming done to meet the requirements. This would be at the least 18 months to do a proper design, development, QA, User testing prior to release for beta and general availability to our customers.
2. Please announce which vendor developers were allowed to work with the draft Test Scenarios. This should be opened to all vendors who have a certified product.
3. I may have missed this but are ATLS going to be required to include the testing scenarios as an alternate way to test for 2014 certification? Thank you.
4. Interface Design: Strongly agree with Dixie Baker regarding standardization of interface design, building, and implementation. Such an effort would likely (hopefully) lead to a reduction in costs.
5. There are only 161 total products certified for the 2014 Edition from very few vendors compared to the 2011 Edition. Many vendors are not taking a cautious approach. they are scrambling to do all required development to meet the MU2 requirements. Will there be enough certified products for all Stage 1 attested EPs & EH/CAHs.
6. I wholeheartedly support the suggestion to narrow the number of S & I initiatives or provide information concerning the regulatory (MU3) focus of a particular initiative. thank you.