



**HIT Standards Committee
Content Standards Workgroup
Transcript
December 12, 2014**

Presentation

Operator

All lines are bridged.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Good morning everyone this is Kimberly Wilson with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Content Standards Workgroup. This is a public call and there will be time for public comment at the end of this call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I will now take roll. Andy Wiesenthal?

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Rich Elmore? Calvin Beebe?

Calvin Beebe – Technical Specialist - Mayo Clinic

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Charles Jaffe? David Dinhofer? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Grahame Grieve? John Klimek?

John Klimek, RPh – Senior Vice President, Standards and Information Technology – National Council for Prescription Drug Programs

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Joyce Sensmeier? Kelly Aldrich? Kevin Kirr? Kim Nolen?

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

Hi, I'm here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Marjorie Rallins?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Susan Hull?

Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Clem McDonald?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Dianne Reeves?

Dianne Reeves, RN, MSN – Associate Director for Biomedical Data Standards, National Cancer Institute – National Institutes of Health

Present.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

And Kin Wah Fung?

Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

From ONC do we have Matt Rahn?

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

Here.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Is there anyone else from ONC on the line?

Mazen Yacoub, MBA – Healthcare Management Consultant

Mazen Yacoub.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Great with that I'll turn it over to you Andy.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Thank you, good morning I'm delighted to be here although under somewhat constrained circumstances. I would say Rich Elmore's apologies are because his wife is having a procedure and so he felt that he needed to focus his attention on that. As it happens I joked with him, we must have been twins separated from birth my wife is also having a procedure but hers is a small deal so I'm able to run the meeting this morning while I'm waiting for her to finish.

Anyway, so, I think that the agenda today is pretty straightforward we're going to have a presentation from Brett Marquard to talk about HL7's work on the C-CDA and then a brief review of the work plan and then we will have public comment and adjourn.

So, if there are no questions about the agenda I think, as long as Brett is on the line, and I'm hoping that he is, we can proceed with that. Is he there?

Brett Marquard – Principal – River Rock Associates

I am, good morning, Andy.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Good morning and thank you for joining us and the way we would hope to handle this for the members of the committee is that unless you have a question of clarification it might be a little simpler to let Brett just proceed with the presentation and then we'll have plenty of time for questions and discussion because he's been really good about not overwhelming us with PowerPoint.

So, I hope you all have the deck and can follow along, unless there is anything else we should go right ahead Brett, thank you.

Brett Marquard – Principal – River Rock Associates

Okay, thank you Andy, and thank you everyone for inviting me this morning. I'm delighted to be here. So, my plan, you can proceed to the next slide, the task after talking with Andy and Rich is to set the stage for a conversation about Consolidated CDA. I know there are varying levels of expertise on the phone, some folks who actually are involved in writing the standard and others who have a baseline, you know, don't have quite as much experience.

And so to start we'll do a quick baseline of what C-CDA is and where it came from, talk about, you know, where documents fit in the interoperability landscape, talk a little bit about some concerns we've seen in the field and responses from HL7 and really kind of open the floor up for discussion on who we can improve interoperability with Consolidated CDA. Next slide.

A quick background on myself, I know many of the folks on the phone, I'm a consultant with a background as a software designer, developer and implementer of interfaces primarily for over five years with EPIC Systems and then have been a Co-Chair for Structured Documents a good time and, you know, led the charge for Consolidated CDA and spent a lot of time on, you know, the recent initiatives data access framework and CDA on FHIR. But, you know, have led development teams both for version 2 and surprisingly version 3 and then of course CDA. Next slide.

Okay, so, if you can think back, you know, it's 2014 it's hard to believe the year is almost over. Rewind to, you know, 2010 going into 2011 the industry was focused on a standard called C32. C32 was developed by an organization called HITSP and the deployment of C32, you know, it was a solid standard for what it was intended...the use case was intended to meet, but it had an underlying assumption within C32 and the underlying assumption within C32 is folks really understood this base HL7 standard called CDA.

So, CDA is the Clinical Document Architecture and within the industry C32 is constrained on CDA as well CDA is constrained...there is a whole ton of different CDA documents. So, C32 as a standard, it wasn't considered a standard originally but over time it kind of evolved into one. It was a really simple document that it's only 14 pages long and so when a developer first picks up C32 they smile and say "wow, this is great it's only 14 pages." And as they dig into C32 they realize it's actually a reference manual to other documents there are other standards they need to read.

But the C32 points to...if you look at the kind of visual at the bottom on the screen it's, you know, a little scattered there but C32 actually points to something called C83, C83 points to something called C80 within C83 and C80 they point to some HL7 references, they point to some IHE references and by the time you're actually implementing C32 you have several documents open and as you reference it, it becomes tricky to actually do the development. And so there is some ambiguity within the standard which of course leads to inconsistent implementation out in the field.

The HL7 community recognized this, folks from the implementation community, you know, fed feedback back into HL7 and, you know, across the board that we needed to figure out how to solve this problem and C-CDA was born. Next slide, please. Next slide, please. Oh, thank you, thank you.

So, Consolidated CDA was, you know, conceived in the winter of 2010 and it started in 2011 and was really one of the first S&I Framework Initiatives, broad stakeholder involvement, 140 volunteers as a total but we had on average over 30 people on conference calls providing feedback on how to reconcile and improve some of the gaps within C32. Next slide.

As a result of all those folks pouring in, all the energy we resulted in...the first draft of Consolidated CDA, it's in a version 1.1 as named in the Meaningful Use Stage 2 regulation and within it, it contains specific document templates.

So, C-CDA you can think of as it's a collection of templates which can be assembled into these specific document types and so within there is the continuity of care document, consultation note, a total...nine in total it's really eight structured documents plus one called the unstructured document.

What these documents do is...so the continuity of care document has very specific requirements of what are to be included in it. So, for example a document is made up of these things called section templates and so sections are allergies, medications, problems, results and every single section...it's very important to note, every section has this concept of narrative text and coded entries. And so if a machine is unable to process the coded data underneath at a bare minimum they can display the narrative text for the end user. And those are kind of requirements of CDA.

Now what was great about Consolidated CDA and one of the kind of changes in approach from C32 is that rather than say, all right you need to be an expert in CDA and now go ahead and read the standard, we said, wow, we're really losing people and so we pulled all the base rules from CDA into this document with the idea that to implement any of these templates all the information you needed were directly included in the standard.

A very simple example would be a medication may require an ID in the base standard or let's say it requires a document ID, okay, every document needs to have a unique ID, and many of the documentations in C32 or IHE and even prior HL7 documents we wouldn't restate, hey, it's important to have a document, a unique document because there was an underlying assumption that you knew CDA and you would know that you're required to include that.

For Consolidated CDA we flipped it upside down and said, you know what let's stop the madness of having to look in all the different documents, let's put all the rules up front and so anything that was in the base standard that applied we pulled forward into kind of a single source document. It made Consolidated CDA very large and so it's a several hundred page document but the way it's intended to read is that folks jump in and read specific portions of the document and you don't read it from page one to the end you just read the specific sections that are pertinent for your particular project.

So, that's a quick intro on Consolidated CDA Release 1.1. Up next I'm going to talk a little bit about the sweet spot of exchange for documents and next slide, okay, thank you.

So, there is a lot of talk about, you know, documents versus messages and services, and you know, the intended sweet spot for documents is, you know, enabling exchange across institutions so to provide a snapshot in time about the actual patient.

So, this is the transition of care scenario between institutions where messages, both v2 and v3, primarily enable exchange within an institution. So, the registration transactions, the lab, the pharmacy, there are of course exceptions to the rules here where v2 is used for some public health reporting, immunization registry reporting, but primarily v2 and v3 are within an institution and documents are between institutions to help support that movement of care between organizations.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Brett, I think that that's too strong. You left out all lab reporting and there are tons of reporting to doctor's offices through HL7 v2 currently and to health information exchanges, so I think that's an overly strong distinction.

Brett Marquard – Principal – River Rock Associates

To say...well, I guess, Clem, as a percentage of exchange...I agree there are a fair...I think as a percentage I still stand and say that, you know, v2 is still primarily within and there are some definite cases and I think at Regenstrief in Indiana it's a unique situation where there is a large amount of lab reporting through that exchange.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I'll clarify that the standards for the Meaningful Use is v2 for lab reporting, from labs to places and all of the big labs do it, use it.

Brett Marquard – Principal – River Rock Associates

So, maybe I should put an asterisk here and say, for lab, you know, there are some pretty good cases where it's beyond institution but as a broad kind of brush v2 is primarily within...

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

So, this is Jamie Ferguson and I guess, you know, Becky and I as Chairs of the Semantics Standards Workgroup where asked to join on these calls, so although I didn't chime in on the roll call Becky Kush and I are both on the call representing Semantics Standards Workgroup.

But, since Clem started off on this discussion I have to comment as well, because, so I'm from Kaiser Permanente and in every market in which we do business the fastest growing number of implementations of inter-enterprise or inter-institutional exchange is new v2 messages that are custom made bilateral exchanges between organizations for coordination and continuity of care and it's because the current document standards, as you described, have insufficient content but it's, you know, in order to get what the clinicians need what we're seeing in every market is the fastest growing mechanism of inter-organizational exchange is new custom v2 messages.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Jamie and Clem, this is Andy, thank you for that but what I might suggest Brett is that you think about, and you don't have to agree or disagree, but think about the definition in the reverse direction that the C-CDA is basically restricted to movement of information between institutions. So, it doesn't do within institutions so the constraint is there rather than the constraint on v2. Do you see what I'm saying?

Brett Marquard – Principal – River Rock Associates

Yeah, no, I appreciate that Andy and actually I really do appreciate the feedback from both Jamie and Clem, you know, I think, you know, the second bullet is probably too strong of a statement and that, you know, document, you know, CDA documents sometimes are used within institutions but...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, they certainly, you know, the messaging within an institution certainly is a real, that's true, okay, it's just not restricted to that I think is the point that Jamie and Clem are making and there is an ample use of v2 messages between institutions. On the other hand...

Brett Marquard – Principal – River Rock Associates

This is where I wish I could cross out the slide, you know, make an edit real time here and unfortunately I'm not able to do that.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

At any rate, just for future reference.

Brett Marquard – Principal – River Rock Associates

Yes.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

And for everybody else's understanding, thank you.

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

Well, the slide is correct it's just not complete.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, exactly.

Brett Marquard – Principal – River Rock Associates

Right, right, absolutely. Well, maybe I want to add to it. So, this is the sweet spot for the two content payloads here. So, before we start talking about some of the issues around Consolidated CDA we decided to do a little blurb on the most recent release of Consolidated CDA if you want to go to the next slide.

So, Consolidated CDA Release 2 was just published Wednesday this week officially at HL7. It added three new document templates, a handful of section entries, removed a few templates that were ambiguous and came up with kind of a new versioning strategy to move between 1.1 and 2.0.

C-CDA R2 took a long time to get to publication because there were so many ballot comments, there were 1000+ comments received, lots of interest in it. It definitely raises...C-CDA R2 raises the bar more could be done but it raises the bar. And if you want to go to the next slide there is a little more detail on what's within it.

So, the three document types that were added were care plan including home health plan of care, referral note and the transfer summary. The other big edition was this concept of a patient generated document, there is a generic template that if we want to record that a document was written by a patient the structure is now there for folks who looked at the standards and said, this was a patient generated document.

And it's key, you know, so there were some tightening of constraints in C-CDA R2, there is always a tug-of-war about how tight to make constraints even as recent as last week on the HL7 Structured Documents Working Group call, which is the committee responsible for CDA, folks requested, you know, why did you make the constraints so tight I'd like to reuse templates from Consolidated CDA but I can't because you made the restriction on vital signs too tight. So, we're always in this tug-of-war about the tightness of constraints, C-CDA R2 improved some of that. I of course, when I think about transitions of care use case believe we could be tighter. Next slide.

So, where implementation is struggling, next slide, and this is a really short list. You know we could go on a very long time about some of the areas, and this is, you know, these are kind of the first couple that came to mind to me and listening both through HL7 and my experience actually implementing CDA.

So, the first, to me the highlight is inconsistent implementation both in the structure that's included and the terminology that's selected. A really simple example would be that we've discussed within HL7 within structured documents is communication of medication and when medication was given to a patient.

If you read the standard it simply says, you know, use effective time, okay, which is an element in CDA and unfortunately it doesn't say, okay, if you want to communicate take this medication every four hours, there is not a prescriptive recommendation in the standard on how to do that. And so, as a result when it got into the field folks have done it a little bit differently.

In terms of terminology, you know, there is some...for suggested units on vital signs in C-CDA Release 1.1 we didn't provide any guidance on vital sign units and while we provided guidance that needed to come from...but we didn't give a suggested set of units. And we learned that that's problematic and so C-CDA R2 provides a recommended set of units it doesn't enforce it but at least provides a list of recommended codes. So, there was some improvement there.

The other kind of, you know, one, you know, issue I seem to field is, you know, there is variability in communicating the same information. So, within a problem section how you record this particular status of a problem or an allergy, it's not crystal clear and you can do it more than one way and unfortunately, you know, when you can do things more than one way it's a real hindrance to interoperability.

Another thing, you know, I've personally experienced that more than on HIE is the idea that everything is a continuity of care document. A continuity of care document is a special document type that, you know, had...C32 was a flavor of C-CDA it was an additional constraint and it, you know, set the stage for folks...since folks had done a lot in development to support CDA they carried that forward and C-CDA in terms of being a real summary of care has turned into almost a bucket where you can try to stick the entire patient's history, which wasn't the original intent of CCD.

Consolidated CDA includes CCD as a document type but there are seven others that are allowed plus the unstructured document and so with the idea that those are typically tied to an encounter, so after a hospitalization a discharge summary would be generated at the end of a visit and that would just contain information from that particular hospitalization, it wouldn't contain a summarization of everything that has happened to the patient in the last five years, which is what CCD has become and I should say, you know, some places it asks for more than five years to put a new CCD which creates a large document and really stretched the intended use of CCD.

Another issue that, you know, change is coming of course, C-CDA R2 was just published this week and implementation will be beginning on that, you know, I have heard vendors, you know, some vendors have been closely tracking that spec and, you know, development will start for folks who plan to support it in some capacity next year.

And the transition between C32 and C-CDA is...there is some room for improvement in how we transition between versions of the standard and I think that's an important conversation that we need to have within HL7 and other places to give clear guidance to the implementation community. Next slide.

So, you know, how do we improve...there is a baseline of a few issues I'm sure folks on the phone can add several more to the pile and I'm happy when we get to the open discussion to hear more. So, you know, what's been done to try to improve C-CDA or how could we improve C-CDA implementation.

This first bullet, it's funny I've added this based on, you know, looking at the presentation of EHRA and learning that some EHR vendors aren't able to display any CDA document. You know going back to the base standard the idea of CDA was if you don't have a sophisticated system that can do machine processing, you know, decision support and import data into your database, at a minimum you should be able to display it.

One of my favorite PowerPoint slides that is used at HL7 in the internal CDA is a POM pilot displaying a CDA document. Now it's not that fancy but, you know, POM in the 90's could display CDA with just a simple application of a style sheet to XML and, well, you know, we don't want to recreate the electronic fax machine here it should be a minimum requirement that any vendor should be able to display any CDA document.

Another area for improving C-CDA implementation is simply more examples. I'll talk a little bit more on that when I talk about what HL7 has done, but more examples, developers, you know, are very clear, for better or worse examples are a way to learn but also to see exactly how the standards community intended someone to implement a particular template.

You know another area, you know, ideas to improve is test by domain, you know, C-CDA has, you know, within a particular document there, you know, could be over a dozen sections and when you think about an individual HL7 version 2 message type such as, you know, sending lab or sending immunizations imagine, you know, C-CDA documents wrap all these up in a single document and the expectation is that it's just, you know...I should be careful, but it's no more complex than, you know, doing a simple v2 exchange when in fact it's...you know, you're including several domains and it's very tricky to put them all in...to send them all at once and so one thought in terms of improving implementation is, you know, really focus on the top problems, allergies, medications, immunizations, lab and make sure, you know, slowly work through it and confirm that, you know, you've got the scenarios you want to cover right and everybody's doing it exactly the same way to improve, to confirm consistent implementation.

Another big opportunity for C-CDA and not just C-CDA but really any interoperable exchange is making it public so where to find the value sets, so determining the concepts that are intended to be sent. So VSAC of course is an incredible resource for quality reporting and there have been some really great discussions about adding the Consolidated CDA value sets to VSAC and very optimistic in the early 2015 that will also be present.

You know other ways to improve C-CDA is to really bubble up the issues. I think, you know folks talk anecdotally about, you know, I have this problem here or there but, you know, really making sure we have a public place to collect issues that either, you know, HL7 or other organizations can weigh on and then provide solutions and, you know, ways that we can agree and move forward.

And also tighter constraints, there definitely are places that could be tightened up in Consolidated CDA and of course tighter constraints lead to more consistent implementation which is a requirement for interoperability. Okay, next slide.

What has HL7 done thus far, so in structured docs there is a Workgroup, you know, many folks are familiar, it's a Workgroup that meets weekly for ongoing projects it's a public call where, you know, averaging around 25 and it ranges 15 to probably 35 per week, and, you know, we spend a lot of time on new projects within structured documents but we're very happy to discuss ambiguities or issues with the standards and being responsive to folks who do present specific concerns.

And one of the things that has grown out of that is the Examples Task Force. So, the Examples Task Force is a group, it's actually growing, it was started with about five or six people and, you know, we're averaging a dozen plus each week folks showing up where we have vendors actually presenting...we're actually looking at XML and saying, all right, I am trying to say "I have no known allergies" what is the proper way to do this.

There is some guidance in C-CDA but there is not an explicit sample to go with it. And so the group gets together, there is a proposal, you know, we review it and then we actually vote to approve them and we don't just approve them in the Subgroup, we approve them...we first approve them in the Subgroup and then we present it to the large group, we give them a week or sometimes two weeks to review to see if they have any concerns and then we officially approve it.

And so we have 30+ approved samples posted to Wiki, there is a link in the presentation. And we plan to continue to meet every Thursday and really are focused on some of the high priority Meaningful Use identified domains but are happy to go in ones that aren't necessarily required in Meaningful Use if folks are presenting from an implementation experience that they need help on.

This has been, you know, a very positive Workgroup, we've had vendors, you know, good support from Allscripts and EPIC, and Iatric Systems, and Diameter Health who are committed to kind of flushing out, you know, areas that...ambiguous areas of the standard.

Another piece of HL7 is the Help Desk which is a member's service where you can submit issues to get response from a set of hired staff within HL7. Next slide.

So, one other thought and, you know, this is a really...again to cover all the issues, to set the stage or conversation about Consolidated CDA is, you know, the vendors go through a rigorous certification process, they're given a set of scenarios, they go in and they approve, they test their system and that sets the bar. And then after that they're cut loose to go into the field. And there is not a strong feedback loop of, you know, how successful are implementations, you know, how successful are folks in deploying C-CDA.

So, one thing that's been on my mind recently, and I know others too, is how do you, you know...and of course I have some ideas, I'm very interested to hear yours and if this is something that should be pursued further is, you know, how do we measure the success in terms of, you know, consistent implementation of standards but, you know, of course improving care.

So, with that I'll pause, I promised Andy and Rich I'd keep it short, but I welcome, you know, any questions or of course comments on ideas to continue to improve the actual standard but also really how to improve the field, the implementation in the field.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, Brett, this is Andy and thank you very much both for keeping it short but also for a cogent presentation. It's important always I think to sort of set a base level of understanding of the kinds of things that a group is going to be working on and this is very helpful in this domain.

I'll take advantage of the bully pulpit and ask a question not just for you but for the whole group, if you go to your ascertain that the CDA documents contain large amounts of data and it's easy to get lost, what do you think...and this is for the members of the committee as well and Jamie I know you're a liaison but you're welcome to contribute too.

What would be a way of, in a systematic way, reducing the complexity perhaps like building blocks of C-CDA that are easily moved from one template to another and don't have to be recoded every time or is that a nonsense question? No one? Brett?

Brett Marquard – Principal – River Rock Associates

Well, thanks, Andy, you know, I mean, I think it's interesting to hear the comment from Jamie and Clem about, you know, C-CDA not...within the complexity not getting what they wanted and then kind of reverting back to version 2 and I guess what I...you know, to add to your question is, I'm curious, you know, if there are specific domains beyond lab where that...and I can think of some that are likely that may have stepped over to version 2 to do that and then, you know, what could be done to feed that...so, you know, how that transition, you know, how that decision was made and then what could be done to improve the standard so that...you know, for folks who do go in the future to use C-CDA that it would be clear on how to use...how to implementation that particular domain.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, could I just...this is Clem, it's not just the...really there are different purposes and different ways. C-CDA when you start to figure how you're going to accumulate the results that may be coming on the same CDA and dealing with duplicates it's much harder because you don't have specific ideas deep into the...like the individual test results or the individual drug.

So, there are some other issues to consider, well, HL7 was planned as sort of the parts were to be accumulated inside and there was messaging developed to manage that, which is not yet in CDA. So, I don't think that should be the focus. I think the focus should be on how you could make the document digestible. It's too bulky and it doesn't have to be. I saw a document that was a CDA, well, it was not a CDA it's a...well anyway it's a document that had three pages of tables and it got converted into a CDA and it became 76 pages.

So, I think using tables would help a lot. Have a sort of consistent or a good structured entry point outline structure, I mean, as a clinician I couldn't figure out where the hell the lab stuff was, well it's part of the history and physical, but in most...I'd never thought of...history was you talked to the patient, physical is the examination, I've never thought of a lab as being a component of the history and physical, I maybe out of date, but a good outline so you could sign entry points, you know, to the things that are inside of it would help a whole lot. But the bulk is due to I think this whole narrative approach and set of tables. I think the information is good it's just hard to see it.

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

So, this is Jamie, I will chime in, I have I think a different perspective than Clem and just so you know that I'm coming from a place of love in terms of this, I was both involved in the original drafting of the C32 but also working with Keith Boone I first documented the idea of using templated sections in CDA that turned into the C-CDA and I presented that to the Standards Committee as an idea for the first time and so I'm very happy to see this progressing.

What I would say, though, is that where or perhaps one of the areas where we could have taken a different approach was that we tried to identify data requirements for highly generalized scenarios without looking at highly specific use cases and so where we're finding the need for new version 2, you know, custom point-to-point messaging is where patients are in a chronic disease management program for cardiac care for example or for transplant coordination is a great use case, you know, these are particular scenarios where we're finding that, you know, the existing CDA templates don't have the data that clinicians need and that's driving us to version 2.

So, I think that looking at a variety of some of those very specific scenarios where clinicians are demanding more or different data then validating the content of the C-CDA sections or templates against those particular requirements could be a really useful exercise.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, I'm hearing, thank you Jamie and Clem, I'm hearing maybe in a sense Brett an answer to your question about measurement, you know, should we measure the impact in the field and maybe that's key to the improvement cycle as you correctly pointed out which is finding these high volume use cases that aren't well handled and seeing if there is a way to handle them and at the same time reduce complexity, you know, that may be a tall order but so measuring the volume of transmission of information that's seeking to support continuity of care and what and how you characterize each message type like care for transplant patients or management longitudinally of somebody with HIV or the messaging back from an oncologist about current status of the cancer patient to a primary care doctor things like that.

And I'm not suggesting that I know which are the high volume use cases, but finding out what they are with the help of some helpful large care systems and then finding out whether or not they're addressable easily with C-CDA or they're resorting to v2 might be a way to point the committee in the direction of certain kinds of improvement techniques and strategies. What do you think about that?

Brett Marquard – Principal – River Rock Associates

I think...Andy I think that's interesting and when you think about the...it's funny the comment about, you know, v2 for...I really appreciated the comment from Jamie about, you know, being used in cardiac care and transplant coordination and I think, you know, understanding the others areas where, you know, folks have swapped in other standards other than CDA where CDA was probably thought as the original top kind of contender, I think it would be very interesting to understand at HL7...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...

Brett Marquard – Principal – River Rock Associates

Yeah?

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Other contributions, I'm sorry, somebody was about to say something?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I was, but I've already said something so I'll wait until someone else says something, this is Clem.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Calvin Beebe – Technical Specialist – Mayo Clinic

This is Calvin, I was going to offer up, I know that there have been a number of new implementation guides on CDA that are leveraging some of the Consolidated CDA templates, there was one in cancer reporting and statuses that was specifically focused on cancer treatment and keeping people informed downstream.

So, some of the...one of the interesting things we've seen in the HL7 arena is the practice community coming and saying they want to create these kinds of documents and I'm not sure what the status of that particular implementation guide is but I know it was in process at one time.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Thanks, Calvin.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

If we could get back to the point about CDA and that it's got a good purpose and as it gets better it will be great, but it's a document, it's a packaged one-time thing and it hasn't addressed the issue of trying to take that data from many of those documents and putting it into a central place, a medical record system and being able to identify which one came...you know, because if people accumulate they take results from other sites you're going to have a lot of this same stuff coming in from multiple CDA's and how do you know which is which, and how do you know which is really the right one.

So, I think getting the identifiers down to a smaller granular level and think about it more like a messaging system would help for those purposes.

Brett Marquard – Principal – River Rock Associates

I just want to comment back Clem, I think the idea of, you know, CDA and C32 and, Consolidated CDA being developed in this way to meet this kind of generic scenario of, you know, just kind of generic broad brush of, you know, transitions of care and I think it's a really strong point that, you know, tightening...not only tightening the standard but tightening up the actual intended workflow and how, you know, not necessarily defining how systems...whether they should ingest it or exactly, you know, adding new system requirements, but at least outline, you know, tightening it down a bit more from the generic, you know, this is to be used to move between more institutions but try to give...I think there is room to improve and add additional guidance there.

I'm not exactly...I'd have to think a bit about whether the best place to do that would be from HL7 or another place, but I definitely think there is room to provide additional guidance beyond what we currently have.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, that's...and I'd like to come back to the presentation of the document, it just shouldn't have to be that big and that complicated. And I think it comes off because its machine generated, there is not a human artist kind of worrying about it, there isn't good entry points to go to one thing and find...you know, like finding labs.

I couldn't find the section on labs. There is a nice section on imaging reports but the section on labs is part of the history and physical which I don't think any physician will think it belongs there. But if you had an entry point it wouldn't matter, but right now it's a heck of a job to find the parts and the pieces in a 1200 page document.

I think that would be an easy fix to put a level on top where you've got, you know, 40 things and you can, you know, link to them immediately.

Brett Marquard – Principal – River Rock Associates

Yeah, well, Clem and I want to...you know, I appreciate you making that comment because it's, you know, the CDA is focused on the structure to move the data between the systems and we don't spend...and we've been very careful to not spend time on how it's actually...you know defining how it's supposed to be used within those systems.

So, when you talk about having to hunt around within a document I've seen, you know, within the...with HL7 we provide a style sheet that gives you linking so you can link directly to the results and the medication sections and I've seen vendors who use the...since the CDA is split up into these sections within their application do processing to pull specific sections out of the document and display it, you know, alongside what is currently stored within their medical record to support reconciliation.

So, there is some capability to do that slicing but it's not necessarily something that within the standard we spent much time talking about.

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

So, this is Jamie, I would like to...I'm sorry for talking so much, but I do want to contribute one more thing, because it just became clear to me...really I think one of the key differences between the perspective that Clem is talking from and the perspective I'm talking from is it seems that Clem is talking about the receiver of the CDA as a human, an individual physician who is going to take this document put it on a view screen and actually navigate with their eyes and their mouse and so forth whereas in our case that never happens.

The receiver of the CDA is a machine that knows where to find the different pieces so it doesn't matter if it's a 1200 or 2000 page document because the same data is going to be in the same place from that sender every time and so it's the program that knows where to find things and so that's not a problem that we have.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I wasn't talking about really the physician or the lab receiving it, I was talking about the programmer or the reviewer, which from my perspective, trying to read the darn thing.

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

Okay, but, yeah, but the programmer does have that problem one time but then for, you know, for thousands of transactional instances you don't have that after the first mapping.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

There are different levers but if it's hard to read you're going to have differences in interpretation and some of the problems of implementation are due to this.

Brett Marquard – Principal – River Rock Associates

Yeah, let me...Clem, I think, I just want to jump in and Clem I think when you talk about difficult to read I believe you're referring to, you know, within a section some vendors are generating texts from the coded entries and so that...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, there are two different issues, there is the XML you get and the other problem is it comes differently and differently than intended. And I think part of that is due to the fact that it's hard for a developer to quickly digest this and understand exactly what it's telling them to do. That's what I think.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Right, well, you know, I'm going to step in here and say that I think that this is actually something we can discuss further. We can talk about it all day today but I'm not sure that we can adjudicate it right now and...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, could I add just one more point?

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Sure.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I read FHIR, the first round a year or so ago right after I dug through the 900 page of the CDA, it was not painful to read, it was not hard to find stuff. So, that's I think is the way...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, now I'm a little confused by your comments, Clem. I think what...you're talking about two separate things one is you're talking about the document that describes how to...what the standard is and how to implement the standard and that it would be nice to have a reasonable way to quickly navigate through it to get to the part that you want if you're an implementer...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Correct.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

That's one comment. The second comment or set of comments I think I've heard you make is that if you are an implementer and you're attempting to implement around a specific document type that's going to be coming to you that when those document types come to you, you know, they're packed with all sorts of information, they're very lengthy, sometimes it can be repetitive and it may not be placing the information in the places where you would if you were a clinician coder. So, those are two separate things.

Jamie talked about the second one and saying, well, you know, do it once and then you've sorted the issue.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yes.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

I think the first thing is a strong recommendation to Brett and to the SD Working Group at HL7 to say, look, you know, you produced a massive document, it's full of great stuff but it's hard to navigate, can't you use some link tools to make it easier to get to your point of entry as a developer.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That's actually the point I was making. I really wasn't as worried about the XML.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

When it comes to users maybe the header has them confused, I hadn't thought about that. And I also think tables could be used much more generously to make it easier to read.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Version 2 should have tables and make it easier.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Good, I know there are other people who are at least, I hope, listening and I'm wondering if anybody has any other comments on this presentation for Brett?

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

All right...

Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting

Good morning, everyone, this is Susy Hull. May I go ahead or...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Absolutely.

Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting

Thanks, I didn't mean to interrupt someone else. Susy Hull I'm a nurse entrepreneur and an informaticist and I would be interested maybe just in some off line conversation to see how those examples that you're growing and building, particularly with your Thursday meetings, are looking at the plan of care kind of scenarios and if there is some help for that.

And the particular interest I have is seeing that not only can we share those care plans dynamically among, you know, settings and entities, and actual transitions of care, but are we preparing the way to be able to share those with actual patients and then actually share and improve those with both patient generated information or improvements as well as provider.

So, I'm just wondering where you think the community is and what might be some work that can be done on that in the coming year.

Brett Marquard – Principal – River Rock Associates

Thank you, Susy, it's sort of a really, really great question and the initial release of C-CDA Release 1.1 kind of glossed over the plan of care and...care plan and kind of hit a placeholder to say, all right, if you're going to put information here's where it goes and so I think the original release of Consolidated CDA and the release that's in the Stage 2 language is pretty light, but the most recent Consolidated CDA, which was just published this week in Release 2 as a new document template specifically supports care plans and, you know, discussed, you know, the kind of key components with the idea that this would be...how that would be shared with patients and providers and, you know, I would consider that a sort of very, very good first take at it and, you know, there is going to be more discussion on that.

And at some point that may move into the Examples Task Force, you know, as that goes out in the field, but I think, you know, I think that conversation really gets started with the most recent release of Consolidated CDA and through the next, you know, year, 2015 and I think probably it will continue beyond, is how to really deploy the concept of care planning with both the patient and other providers.

Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting

Yeah, thank you, I was just at the mHealth Summit and there are a few interesting mobile technologies that are starting to actually get some traction in the field. So, it will just be an interesting I think story for us to start to following. Thank you.

Brett Marquard – Principal – River Rock Associates

Great, thank you.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Other comments or questions from the committee? Well, all right, hearing none, this is a good discussion, I'm grateful to Brett for pulling it all together. And Brett do you have any final comments that you'd like to make before we move onto our next agenda item?

Brett Marquard – Principal – River Rock Associates

You know Andy, I would just say, you know, thank you for inviting me. And for folks, you know, if you run into issues with C-CDA, you know, please...at HL7 structured docs we have a wide open door policy, you know, we really...folks, you know, especially, you know, directly implementing, we love to hear from you and do, you know, everything we can to help clarify the standard and give feedback to improve interoperability.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Thanks.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Hey, Brett, this is Clem again, is there a one stop where one can get a bunch of actual C-CDAs that people are producing but are de-identified to test them or try them?

Brett Marquard – Principal – River Rock Associates

Clem, there is a repository that the smart CDA project put out, but Clem it's actually...I appreciate you asking that question because it's one of the things that I would, you know, you talk about...people dream about weird things and one of the things I dream about is every single certified vendor in the country submitting their, you know, what C-CDA they use for certification against the NIST test script to a repository. Now we don't have that broad, that's my dream, but what we do have is there is a GitHub repository out there with some samples that you can grab Clem.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I think your dream is a good one Brett. I would push it.

Brett Marquard – Principal – River Rock Associates

All right.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

All right, thank you. Thanks, again, Brett. So, if there are no further questions about that I would again thank Brett for coming and for giving such a cogent presentation on the state of affairs in C-CDA.

I'd like to move on briefly to the next item which is laying out our work plan for the coming months so we can move. I'm not unfortunately able to do the WebEx but I can see the slides. So, there is a slide about upcoming FACA milestones, I don't think we need to spend a lot of time looking at that, there is just a series of events that are taking place during the first and second quarters of 2015 since we are basically about done with quarter four of this calendar year.

The next slide shows you the Standards Committee Workgroups and Chairs and as Jamie mentioned he and Becky are the Co-Chairs of the Semantic Standards, Rich and I Co-Chair this group and it's expected that we are, as Co-Chairs, going to be liaison members of each other's Workgroups and add to the mix of communication between the Workgroups, because there is a substantial amount of overlap as you might imagine amongst our activities and hopefully all of that will be managed by the Steering Committee which is Chaired now by Jon White who I hope all of you know has become the Acting Deputy Director of ONC, and is well known to almost all of us from his activities at AHRQ and the indomitable John Halamka.

So, moving onto the draft work plan, I think you can see that we are marching steadily through the informational presentations that are described for the last quarter of 2014 and we will, at our next meeting, have a discussion, a presentation on the interoperability roadmap to get the same...we've had some context from the EHRA around C-CDA, Brett's presentation from the HL7 perspective on C-CDA and now a discussion of interoperability roadmap.

You should all have received, in the last couple of days, calendar invitations for the combined meetings in February and so we're on track to have that happen. And then we have a charge to respond to the interoperability roadmap and I think, you know, all of us will also have seen the strategic plan and probably won't be able to resist commenting on that as well.

So, I will just leave the rest of the draft work plan to you for...just so you could understand the direction that we're taking. I'm sure this is going to change some as time goes on, it may not be that we accomplish it as quickly as we would like, but I think that we're making the kind of progress that we're supposed to make at this point meaning we're learning or trying to learn the things we need to learn in order to add our opinions to the Standards Committee overall work. Are there any questions at all about the work plan or what's before us for the next couple of quarters?

Okay, well that was quick. So, again, next steps, there is a series of documents for you all to take a look at. We are going to be hearing about the interoperability roadmap. We will be having work to do to report to the Standards Committee and then there is a joint meeting of the Standards Committee and the Policy Committee coming up in February where a lot of this will be discussed then and actions taken.

If there are no other comments I know that we've gone relatively quickly through the agenda, but I think we had a reasonable discussion and reasonable participation. So, I think, you know, in the...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Go ahead, Clem?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, I didn't want to...I had a lot more and didn't want to get into it, but I want to do one more luge thing about, you know, I think the planned directive has got to be to get clinical data into the medical record, now especially that stuff that is machine generated already in other systems and I think this time around we're getting close and in pretty good shape with radiology reports but they still haven't touched EKGs, EEGs, spirometry there is still a whole bunch that aren't either specified or represented in C-CDA or talked about in any of these meetings and I really think, you know, we're wasting an opportunity to get easy data into medical records by not focusing on some of these things that exist in other machines.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, so they're really three things, one is waveforms, you know, images themselves and the third which sort of overlaps is the commentary or interpretation of the waveforms and images.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I wasn't emphasizing the waveforms, EKGs are really structured documents plus a picture with an impression they're just like a lab test except for the waveform. But the whole fact that we're not focused on them and saying, how do we get EKGs in bothers me. They are a billion dollars a year test and they're useful. And spirometry and EEGs, and there are a lot of other ones, it's really not the waveform it's the report.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Right, but a lot of the clinicians who are doing continuity will want to see those waveforms and manipulate them.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

And they're relatively easy, PDFs give them to you pretty well and that's how a lot of EKGs are shipped...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

By the current standards, by H version 2, I hate to say.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, so, anyway point well taken and I think we can...we haven't been charged with that but we can certainly try to incorporate it into the...a set of discussions...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, it's a general...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Around...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, it's general test results that are left as a, you know, just sort of an open ended thing in CDA which I think we should focus on...

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I think we just didn't get it in.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Good. Any other comments like that or...suggestions for the work plan for the coming year? All right, thank you. So, I'm going turn it back to the staff and I think we're in line to have the microphones and phones open for public comment if there are any.

Public Comment

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

Great, operator, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press *1 at this time.

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

We have a public comment from David Tao at ICSA.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

All right, please go ahead.

David Tao, MS, DSc – Technical Advisor – ICSA Labs

Hi, thanks, this is David, thank Brett for his presentation I've enjoyed working with Brett and structured documents over the past few years. I'd like to say, Amen, to his point about all vendors should be required to be able to display all valid CDA documents.

But I'd like to comment on two points that go beyond what he recommended, first the group discussed the criticism of some CDAs, C-CDA's being too large and difficult to use. On the one hand they're forced, by regulation to contain, at a minimum, the MU 2 required data set. However, I think there can and should be much more and better practical guidance on how to do that while also being streamlined and useable.

So, for example, MU2 says you have to include problems, medications, allergies, results, immunizations and so forth, but there is a huge range within medications of what you could include versus what you should include, you know, every medication they ever took their whole life, probably not, same with results, every result for their whole life, no, so the same with problems.

So, if a provider were to use...were limited to say, faxing a report to another provider they obviously would not fax the entire historical record but they would use some clinical judgment. Maybe with EHRs it's too easy to push a button and just default to whatever the EHR sends which may be too much. So, I think the industry does need guidance and best practice on how much to include within the required data sections and I think that's mainly policy and clinician guidance rather than a technical issue.

Second point, I think there...I've heard many say there is difficulty consuming the data from problems, medications and allergies perhaps because of variations in how they're sent and lack of constraints as Brett mentioned. Those are the only types of data where MU 2 requires discrete data to be consumed.

It would be great to specify how to consume other types of data as well, but we need to start somewhere, so I suggest that a sharp focus on problems, medications and allergy consumption would be a good next step. There has been little to no regulatory guidance or Standards Committee guidance, or S&I Framework guidance on consuming discrete data from C-CDA.

And finally, I do have one question, though I realize you don't have to answer questions, but is it the charge of this Content Workgroup or any other group to make specific recommendations about constraining the C-CDA. Thank you for letting me comment.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

You're welcome, Sir, I'll answer your question, this is Andy Wiesenthal, in a general sense, the Content Workgroup's charge is to make recommendations to the Standards Committee. So, if we have them we can make them. All right any other comments?

Kimberly Wilson – Office of the National Coordinator for Health Information Technology

There is no other public comment at this time.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, again, thank you all to everyone from the committee and others who participated and enriched the discussion today. I don't want to miss the opportunity to say it's a pleasure to work with such bright motivated people who are always giving of their time and their intellectual energy to make healthcare better in the United States and I wish you all a wonderful Holiday Season and I hope that we have a great time working together on the committee. I promise you, I hope that Rich and I will not be constrained by spousal procedures at the next meeting and I look forward to speaking with you all then. Thank you very much and good bye.

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

Thanks, everybody.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Take care.

M

Thank you.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Thanks.

Andrew M. Wiesenthal, MD, SM – Director – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Bye-bye.

Public Comment Received During the Meeting

1. Link to C-CDA sample repository: https://github.com/chb/sample_ccdas
2. Link is on the ONC SITE page: <http://sitenv.org/c-cda>

3. I thank Brett for his presentation, and have enjoyed working with Brett and Structured Docs over the past few years. Amen to his point about all vendors being required to display all valid CDA documents. I'd like to comment on two points that go beyond his recommendations. FIRST: the criticism of CCDAs being too large. On the one hand, they are forced by regulation to contain at a minimum the MU2 required data sets. However, there can and should be better practical guidance on how to meet the letter of MU2 while also being streamlined and useable. For instance, MU2 says you have to include Problems, Meds, Allergies, Immunizations and Results, among other things. But "Meds" could range from all meds ever, to all meds administered during a hospitalization, to only the current med list. So which is recommended? Same with Results: which results? Same question with Problems. Clinical judgment would be applied if one provider were FAXing a report to another provider, but perhaps that's being skipped in some providers' generation of CCDAs. SO, the industry needs guidance and best practices on "how much" to include within the required data sections – this is mainly policy and clinical guidance, rather than technical. SECOND: there ought to be a sharp focus on how to consume the data from Problems, Meds, and Allergies, which are the only types of data where MU2 requires discrete data consumption. Of course, it would be great to specify how to consume other data as well, but we need to start somewhere, so I suggest that focusing on Problems, Meds, and Allergy consumption is a good next step. There has been little to no regulatory or standards committee or S&I Framework guidance on discrete data consumption from CCDA thus far. Finally, I have a question (though I realize no one needs to answer it). Is it the charge of this Content WG, or any other group, to make specific recommendations about constraining the CCDA?