



**HIT Standards Committee
Content Standards Workgroup
Final Transcript
March 29, 2015**

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio 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 the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also as a reminder, if you are not speaking, if you could please mute your line that would be appreciated, after we take roll. Also, in the past we had...people had been submitting some public comment through the webinar and we had been making that part of the transcript, but we will start to share that during the public comment period at the end of the meeting. So, just a reminder to those folks that that could be shared during public comment and with that, I'll take roll. Andy Wiesenthal?

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

Here.

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

Hi, Andy. Rich Elmore?

Richard Elmore – President, Strategic Initiatives – Allscripts

Here.

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

Hi, Rich. 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

Hi, Calvin. Chuck Jaffe?

Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

Here.

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

Hi, Chuck. Clem McDonald?

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

Here.

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

Hi, Clem. David Dinhofer?

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

Here.

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

Hi, David.

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

Hi.

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

Dianne Reeves?

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

Dianne called apologies in as she's not going to be attending.

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

Is Larry Wright in for Dianne? No, okay. Floyd Eisenberg?

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

Here.

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

Hi, Floyd. Grahame Grieve? Jamie Ferguson? John Klimek? Joyce Sensmeier? Kelly Aldrich? Kevin Kirr? Kim Nolen? Kin Wah Fong? Marjorie Rallins?

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Here.

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

Hi, Marjorie. Becky Kush? Susie Hull?

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

Good morning, Susie Hull.

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

Hi, Susie. 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

Yes.

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

Hi, Matt. Anyone else from ONC on the line?

Mazen Yacoub, MBA – Healthcare Management Consultant

Mazen Yacoub.

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

Hi, Mazen.

Mazen Yacoub, MBA – Healthcare Management Consultant

Hi.

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

Okay, with that I'll turn back to you Andy and Rich.

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

Why don't you go for it, Rich, not much to say to introduce things today, I don't think.

Richard Elmore – President, Strategic Initiatives – Allscripts

Yeah, so we're into the Stage 3 review process, in a way this is probably the most critical task this group will have as it probably has the most immediate impact on how things are going to move forward here. So, we appreciate the three subgroup leaders that have taken on...taken the reins and started to move those conversations forward. We think that's really important that we get all of your input; we then

consolidate it back as a combined workgroup for feedback to the HIT Standards Committee, which will be happening over the next several weeks.

And we just encourage you, if you have time after this shortened call to be able to meet as a subgroup to do so as a way to advance your own thinking. It's actually a great exercise once you get into it, so, look forward to your feedback. And I think for the majority of the time today, we're going to focus on one of the three groups and get a work in progress update from them. That would be...

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

So with that and Michelle...go ahead.

Richard Elmore – President, Strategic Initiatives – Allscripts

...so with that I was going to turn it over to Calvin to lead us through that and then...

Calvin Beebe – Technical Specialist – Mayo Clinic

Sure. Sure, that sounds fine. Should we go ahead and proceed? I think you have the PowerPoints there. This will be a kind of report out from group 3 of where we are in our draft response. You can see our assignments laid out. As you look at the assignments, the thing that seems to be more or less the common thread is the use of CDA in some way or another related to the items that were called out. And we'll try to move through the comments that we've created thus far; I have to thank Joyce a great deal for having...being able to put a lot of effort into this. She provided some comments, I've got a few in there and of course we're still open to receive comments from any members, including the other group members, to help us out with the task.

Why don't we go ahead and just start walking through the various items and we'll provide the comments we have and engage in what discussion there may be. So if we go to the next slide. The first one was looking at the transitions of care and for the send and receive via edge protocol, there was a comment that the XDR and XDM for Direct messaging should be mentioned; it's referenced in the 2015 Health IT Certification Criteria and so it was thought that this shouldn't be omitted...the combination of those two protocols should be brought out; also that the...pointing out that XDR provides a significant amount of metadata that can be used.

I think there are other places potentially in the specifications where they called out for what I think is XDM; it's not my strength actually, these protocols, but we're probably going to want to look at this and see if we can provide some additional feedback on that particular topic.

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

But there's an awful lot that...I mean, it's sort of like a montage of things we're asking people to support. Isn't there a way to kind of focus down both XDR, XDM and the Direct messaging?

Calvin Beebe – Technical Specialist – Mayo Clinic

I think the unique...that's...this is Calvin. I think that the unique challenge is the industry is bifurcated or trifurcated right now and so the question is, how do you do that? You could...I think the current strategy is to try to allow this to be supported because it does act as a potential bridging between the two communication strategies, which were the exchange strategy which was originally put up and then now

the Direct strategy. So, I'm somewhat sympathetic to the fact that they'd like to be able to have this metadata transportable.

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

But I mean, are they saying...are we saying it's both of those and Direct should all be...and edge protocol should all be supported? Is that...I mean, are we just mentioning them or saying more than that?

Calvin Beebe – Technical Specialist – Mayo Clinic

At this point they're calling out the use of mostly Direct from what I could see. I did not see any exchange support actually called out, but that's a good question that probably needs more research.

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

I mean for practical reality, if we want to get communication we don't have 40 ways to do it. And if there's some weight in one direction, I'd be inclined to push on that direction.

Calvin Beebe – Technical Specialist – Mayo Clinic

I think this is one of the areas...that's a fair point, but I think this is one of the areas where one solution doesn't necessarily fit all use cases.

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

Well nothing does.

Calvin Beebe – Technical Specialist – Mayo Clinic

And so the email paradigm, the secured email paradigm of Direct is a great tool, but I think the challenge we face is sometimes you need to pull the information and so the other protocols have some benefit in those use cases. So I think it's...I think we have to be cautious in trying to drive to a single strategy which may limit the options that we have in the industry, but I do just...I don't disagree with your basic premise, optionality is driving us nuts.

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

Yeah, and I don't know enough about it either to take a strong position, I don't think I'd encourage multiplicity, we could maybe be more silent, let the industry sort it out.

Calvin Beebe – Technical Specialist – Mayo Clinic

All right. That was for one of the initial components...as we go through...

Richard Elmore – President, Strategic Initiatives – Allscripts

Hey Calvin, this is Rich.

Calvin Beebe – Technical Specialist – Mayo Clinic

Go ahead.

Richard Elmore – President, Strategic Initiatives – Allscripts

One of the other things that I think has come up in previous workgroup calls, and actually I had related this back to the Standards Committee meeting the other week, is that our only opportunity here to try and get something to national scale over the next couple of years, which is really what both patients need and is required by...is to make sure that we have Direct and a more constrained Consolidated CDA working. And so constrained Consolidated CDA is going to take a little longer even than a couple of years, but I think that it's important that we're sending a message to ONC and to the Standards Committee that these fundamentals, which are at least out there and can be refined and built upon, should not...should be reinforced and moved forward, even as we're looking at other different approaches, API-based approaches, that it shouldn't be one for the other that this is sort of important. And I think it's that foundation that we have in both Direct with or without XDR, XDM is something that we need to be supportive of to get to national scale in any reasonable time period.

Calvin Beebe – Technical Specialist – Mayo Clinic

Very good.

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

Calvin, this is Susan Hull; I just have a brief question. Did you talk about error detection on the part of the patient?

Calvin Beebe – Technical Specialist – Mayo Clinic

As we move forward, yeah, we actually covered other aspects of the transition of care, that's actually the next topic that we haven't gotten to yet. We've been talking...

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

Oh, okay.

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

There's some...slide, right?

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah, it's on the slide. We were in favor of, of course, error detection but a comment that I authored was, I think we want to always encourage human readability, even in the event of an error in some of the entries because documents are still intended to be readable and usable. And so the use case of machine processability versus actually being able to read the document and take care of the patient...essentially two different use cases that we need to sort out and not just throw something in the error bucket just because it had a bad code.

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

Hello, this is David Dinhofer. I...jumping forward, I just want to put a comment on that previous thing...previous discussion.

Calvin Beebe – Technical Specialist – Mayo Clinic

Sure.

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

The issue of...to me is that, I mean Rich, I know you want to get...you're saying you want to get it done but the issue is that I don't want to constrain too much because there are a lot of people who are sort of like saying, let's use multiple different cases. So, let's look at it and keep it open. My concern is just that the wording not be too...if CMS takes the wording too strongly, it might say we're only going to do it this way and I want to keep some wording in there to keep the options open for other tools. So I may not have said it perfectly, but that's what I wanted to get out. Thank you.

Calvin Beebe – Technical Specialist – Mayo Clinic

Very good.

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

Well I mean, I think the error detection issue should...there should be sort of a couple of levels, you know, there are the errors which are just, you know, you didn't fit our spec exactly, but the stuff's still coming across, you can understand it. And there's the error that, this isn't the right patient, which we'll get into next. But there are probably some errors that you should alarm about.

Calvin Beebe – Technical Specialist – Mayo Clinic

Understood and again, we were for the logging of all the errors, but we really thought there should be periodic reporting generated out of the systems that could be used by practices to understand not just the errors, but the exchanges that are ongoing with their partners. This may be common in all systems, but...or it may be common in some systems, but we're not seeing it as common in every system.

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

Well I think you're 100% right; we wouldn't have survived at Regenstrief if we didn't have a nightly error report.

Calvin Beebe – Technical Specialist – Mayo Clinic

Right. And again, the curiosity may be nightly, maybe monthly; whatever's appropriate, but we were just thinking logging the errors so they're available really in a timely basis, but not just errors, but the exchanges so that organizations can really manage their relationships.

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

Yeah, yeah. I mean the two big problems we had is patient identifiers and...identifiers because we were trying to file them and we didn't...couldn't file them very well without getting the right identifiers.

Calvin Beebe – Technical Specialist – Mayo Clinic

Finally we commented a little bit about the ability to, let's see, under (A) (5)(B), display in human readable format various documents, requiring that solutions display all CDA document types received. Really, I think the standard should step back and say yes, we want to test documents that are the CCD to consult note, history and physical, progress note, care plan, transfer summary, referral note and discharge summary but in general, they should encourage the implementations definitely to be able to view those, but view any CDA document that comes in. The standard itself was intended to support that with one style sheet across all the documents and so limiting it seems kind of unfortunate.

And then lastly, there is a concern I have that, and it's spoken to later as we talk about the preclusion of the use of the unstructured document type, which I completely understand the rationale for having initially done that because of the desire to have reusability, but I think we need to allow for alternative formats for some documents where we may be getting specialized documents, like waveforms, off of instruments that are recorded in PDFs that are just making it very difficult to figure out how we're going to incorporate those kinds of results in what could be a document exchange, if we don't allow for the support of at least some additional optional formats.

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

Yeah, even flow cytometry has graphical things that are hard to deal with otherwise. I'd also suggest to allow HL7 V2 in these because that would be really handy to...

Calvin Beebe – Technical Specialist – Mayo Clinic

That's an interesting idea.

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

I mean, if Direct can handle it, I mean, Direct could do it, it's just the package inside.

Calvin Beebe – Technical Specialist – Mayo Clinic

Right.

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

Hi, this is David Dinhofer; I have two additional comments. Just on that topic, I know that some doctors are going to have a hard time transitioning to a structured data format and so they may want to add, you know, a field just to have their freehand comments, so to speak, in the. Also, in stepping back, we kind of jumped ahead; let me go back to my screen; on the error detection, I just want to know if this is the right place to mention patient involvement, because I really feel that at least reconciliation where patients can review data. I don't know how to put that in here. I mean it's probably better somewhere else but I did think that patients should be able to help in the reconciliation; so I don't know how to put that in, just a comment.

Calvin Beebe – Technical Specialist – Mayo Clinic

Very good.

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

Thank you, this is Susie Hull; I think that's the same comment I was trying to make.

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

Yeah, I mean you've got a workflow problem thinking we should propose something that we don't know how to do. If the patient's not there when the data's flowing in, you've got to be more specific, I think, give a real solution how this could be done.

Calvin Beebe – Technical Specialist – Mayo Clinic

Being sensitive to time, maybe...since this is just a draft report, I will move ahead and continue on through some of the other areas. Next slide. So here we do have a comment with regards to the

demographics that were enumerated and there was a fairly extensive set of demographics that were encouraged. I...this is a drum I tend to beat simply because I...as an analyst, I continue to have difficulties understanding how we're going to have effective exchange without a singular identifier. So I did want to suggest that at least as an option that it be considered to allow the support of the last four digits of the social security number, because I believe it's been shown to be very effective in reducing and resolving names that have similarities.

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

Well I would support that in space and actually it was in...it was suggested by the HITSP committee, or not the HITS...whatever the, one of our committees suggested that already and it was not included in the NPRM specifically. I think it should be strongly supported; I mean, it's used everywhere, people are doing it in banking, you're doing it in airlines, you're do it in a lot of things and it's not revealing a patient so, I don't know why they're avoiding it. And I...

Richard Elmore – President, Strategic Initiatives – Allscripts

This is Rich Elmore; I would also encourage that we propose some other durable identifiers that have already been proven to work in industry situations; whether that...by that meaning an email address, a cell phone number, something like that that isn't going to hit everyone in the population but may be advantageous following an 80/20 rule.

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

A hundred percent agree because they really were pretty constrained on the set of identifiers they included in the...as required. I don't think they precluded the others, but I would stro...I agree with you, we ought to strongly encourage a broader set.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well, okay, yes, I believe so. Also, there was a comment that I think was a very...Joyce made a good comment that there should be other names just besides maiden names that could be supported because people do change names for other reasons than getting married.

Richard Elmore – President, Strategic Initiatives – Allscripts

And I think the idea there Calvin was that it be changed from maiden name to prior name.

Calvin Beebe – Technical Specialist – Mayo Clinic

Right, right, correct.

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

Good choice.

Calvin Beebe – Technical Specialist – Mayo Clinic

So, a slight change in the wording to support other use cases. And then lastly on this section, there's a good comment about supporting the birthdate, but I did want to throw something in; I don't know if this is the right place to try to deal with it, but it's been detected in actual implementations where HISPs have taken a birthdate that has the time-zone offset included and actually computed a new date of birth from...when it converts it from a local time to a universal time. And this is a completely inappropriate

strategy when that date of birth is used for demographic purposes and for things such as look-up and query which we're forced to use in the above section for identification. So, I think there should be some cautions about the application of any offsets to these fields, even if they're present when that date is used for query purposes in identifying patients.

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

Well the other things about and time of birth, the only reason you need the time is for like 3-5 days after the birth.

Calvin Beebe – Technical Specialist – Mayo Clinic

Understood and...

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

So we need to downplay that, you know.

Calvin Beebe – Technical Specialist – Mayo Clinic

When it's used in that manner it's actually more of an observation than it is a demographic aspect, but...

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

I agree, I agree.

Calvin Beebe – Technical Specialist – Mayo Clinic

...and so inclusion of the off-set shouldn't be precluded, it's just I think it's a refinement that you don't want to apply when you're trying to use it as the date of birth of the actual patient.

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

Well we might actually suggest don't put in the hours and minutes or any of that in anybody past prenatal period, just to avoid that.

Calvin Beebe – Technical Specialist – Mayo Clinic

I think this was a prenatal that they actually changed the date of birth on.

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

They...oh yeah, but it's really a very short period of time, I mean it won't...statistically it won't affect many people.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well, let's not affect any. It's a net and so it's just a caution.

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

Yeah, okay.

Calvin Beebe – Technical Specialist – Mayo Clinic

Any comments on those items?

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

Well this is Floyd. I know in looking at immunization work, one question came up about mother's maiden name is what registries use to identify patients, whether...if we don't...if we're not specific on certain things, it could be challenging, unless public health also changes. And, just thought I'd bring that up. And others have suggested that birth time instead of multiple birth order might be another way to deal with not just the first four days, but young infants for identification in registries. I just thought I'd bring that up.

Calvin Beebe – Technical Specialist – Mayo Clinic

Very good.

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

You know the mother's maiden name is a separate field; it's not an alternative name, right? So I don't think it collides with the question of alternative name; it's a different identifying field, no?

Calvin Beebe – Technical Specialist – Mayo Clinic

Not in all...

M

It should...identifier, it is legally.

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

Yeah.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah, I think it is just another name that can be supported.

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

But it's not another name of the patient, it's another name to help identify the patient.

Calvin Beebe – Technical Specialist – Mayo Clinic

Not in all the structures that are being exchanged like CDA.

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

Well I think that's what Floyd was talking about though, the use of the mother's maiden name as a separate patient identifier.

Calvin Beebe – Technical Specialist – Mayo Clinic

So, just to...this is Calvin. Just a small ned; the CDA standard supports multiple names of which you can call out what kind of name it is as opposed to having a separate named field called maiden name. And so it's supportable...

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

Yeah, but it's different...well it's got a longer discussion. It's a different dimension, it's not my name as a maiden name was Eric, it's my mother's name was her...this is her maiden name; it's a family member name that helps identify you; it's not one of your names. But it may still be true what you said, so.

Calvin Beebe – Technical Specialist – Mayo Clinic

Oh, you're call...fair point. You've...I'll stand corrected, I think you're right.

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

Yeah, I think it's a diff...it's a separate field used for identifying.

Calvin Beebe – Technical Specialist – Mayo Clinic

You're right. A person can have a maiden name, but in this use case I think you're actually calling out...well, I think we need to clarify whether this is the name...and earlier name of the patient.

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

Yeah, yeah and I think if it is, I think prior name is perfect.

Calvin Beebe – Technical Specialist – Mayo Clinic

Right.

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

But I just...well Floyd's point about public health and other contexts, another identifier is the mother's maiden name.

Calvin Beebe – Technical Specialist – Mayo Clinic

So we may need to be careful about this term if it's used, to make sure we have the definition that people are intending.

M

Yeah, will you worry about that?

Calvin Beebe – Technical Specialist – Mayo Clinic

Yup. All right, if it's all right, we could proceed.

Richard Elmore – President, Strategic Initiatives – Allscripts

Proceed.

Calvin Beebe – Technical Specialist – Mayo Clinic

Next slide. So, moving forward, we talked about the updated CDA standard. The challenge that I think that's presented in the specifications of course is the call to continue to generate both 1.1s and in addition, 2.0 versions of the Consolidated CDA documents. One of the concerns is how incompatible or

compatible are these releases? Is there any way...I know there's going to be a great interest in the industry just based on discussions I've had in trying to limit the requirement to have to send both, at least in the overlap year, which...it should only be a requirement for the overlap year, which I believe is...I don't have the year in front of me, but it might have been what, 2018, 2017-2018.

Ideas that were suggested as alternatives to be considered; could we require those systems that convert to 2.0 to maintain 1.1 capabilities to both send and receive? The second, could we construct a converter to convert from one release to the other or vice versa, to support the ability to avoid having to put this functionality in...this dual capability of generating in all the new EMRs? And a question of, could we build a 2.0 version that effectively contained the 1.1 within it; in essence, could we make...is it possible with the standard of 2.0 that a 1.1 processor receiving a newer document could actually process it? This last item is actually a work item at HL7, the Structured Documents group has been technically going through the two standards and trying to enumerate if it's possible to have old software run the 2.0 documents. So we're...that's being investigated at this time.

But, I think the real challenge is that I know practices probably are not interested or excited, and I'm sure the vendors aren't in having to force the dual document generation in this critical overlap period. Any questions on that one?

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

Well I think it's tough, I don't know, do you have the answer?

Calvin Beebe – Technical Specialist – Mayo Clinic

They're doing a very interesting investigation between the two standards. It was not intended to be a significant change, but there are some minor nits, so I think the questions going to be, what's the...in total, does it look like it's possible to suggest the ability to process the newer documents in older software; that's...we see that as possibly one way to avoid the issue that was being identified.

The ability of the software...the newer vendored software to support the old version is really not too much of an issue because most of the certified systems already support 1.1; it would just be a continuation of that capability.

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

Calvin, I'm not sure if you would know or not, is there a way that we could ask HL7 to give us some feedback for our comments back to the Standards Committee?

Calvin Beebe – Technical Specialist – Mayo Clinic

We could definitely make the request; they're pretty active right now, this week, and they've been meeting extensively. What's the due date that we need to receive that by; if I had that date, I could make the request to them?

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

Michelle, do you know?

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

Sorry, I was getting myself off of mute. So the Standards Committee meeting is May 20.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well I would think we could have something by then. So I'll make the request that we ask for their recommendation so that we can refer to it and include it. All right, if there's no further comment on that, we'll move forward to the valid/invalid system performance criteria that was proposed.

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

Which slide are...

Calvin Beebe – Technical Specialist – Mayo Clinic

In general there was agreement that this seemed like a very good strategy to encourage the systems to check against documents to see if they were valid before they'd attempt to process and to look at those. We should involve industry participation to restrain testing scope which is truly realistic and agreed upon. We thought that the...I'm not sure if this was the place where the gold sample, that might be later, so we'll defer that to that later discussion.

The use of restricted null entries, empty sections may not apply to part of the...restrictive null entry and empty sections rules may not apply to specific parts of C-CDA that are used in various use cases. So one of the challenges, with the use of the health IT technology as opposed to EHR framing of the certifications that are coming forward and the expectation to widen the scope of software overall in the healthcare industry that could be certified for various purposes, there's an acknowledgment that we have to be careful about the assumptions that were made in the EHR context for sections being required in all use cases.

Case in point, long-term healthcare facilities, nursing homes may have just different sectional requirements than came out of your typical EHR and so they may have a need to null certain things a bit more than were allowed for EHR systems. So this was a cautionary concern expressed based on the widening scope that's being sought for the use of the technology; that was what that point was intending to really refer.

Propose solutions should actually support viewing of C-CDA documents where possible by applying their local style sheets. Encourage vendors to support the generation of monthly reports. Again, brought back this idea of provide us with monthly reports to summarize were the documents received and where they were sent, along with the error types, if any. So I think there was some additional error type discussion in this particular area and so we encouraged that, again. Any questions or comments on this section?

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

I agree with what you said, and this may not belong in this section but, we had trouble playing with C-CDA's dealing with results that were reported twice. I mean, that is so they were passed on from another report; I don't know if anybody's grappled with that, to know what's really...how do you avoid duplicate recording of results when they're not part of one C-CDA? Someone sent results to the office, they've included it in their C-CDA and you might have gotten them directly.

Calvin Beebe – Technical Specialist – Mayo Clinic

So are these results that they did not necessarily generate themselves but they received through an exchange from another partner?

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

Correct, correct. Even if they generated themselves, I think if they started up a whole new C-CDA, you...I don't think you can necessarily distinguish them, that they're the same as previously. I'm not the expert on C-CDA, so I may be wrong on that. There are some issues if you're trying to take the results up, just throw them in your system, of knowing what is really an identical result.

Calvin Beebe – Technical Specialist – Mayo Clinic

And I think that actually comes up a bit later, in some of the other areas where they...and I don't know if we spoke directly to it, but they did talk about the ability to incorporate the document content from outside sources and then reconstitute them back into the C-CDAs that are generated is actually one of the tests that they're proposing to have.

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

Okay.

Calvin Beebe – Technical Specialist – Mayo Clinic

So it does set us up for dealing with that issue in a greater extent than maybe was necessarily perceived in the first place.

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

All right, thanks; I mean, we can leave it at that.

Calvin Beebe – Technical Specialist – Mayo Clinic

Okay. I know that was in other sections, so; any other comments? All right, maybe we'll move ahead, being sensitive to time; next page. In general I think we simply agreed with the data provenance, but we did...I don't see the comment here, but we did have a comment that we were wondering about the maturity of the data provenance standards and, actually, I'm sorry, I'm not reading what's here. In general we did agree in principle but on the last item, we did think that we might want to include a statement going forward about the maturity of data provenance and it's utilization in exactly these kinds of use cases, Clem, that you were talking about.

We felt that for data incorporated from outside sources, from documents that have been incorporated, ingested with problems, allergies and medications, there needs to be clearly established best practice and implementable guidelines because tagging can get lost if the data's incorporated from external systems that do not manage the provenance very well. And so we're not sure that the...even though there exist standards that made guidance's in this space, we're not sure that the best practices and the maturity of those guidance's have been really proven. And so we're kind of cautionary in our assertions as to how we go forward in this space in the short term.

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

Yeah, I think you're absolutely right, I mean, there's no experience at all and this is like a huge social experiment. You know, laboratory results already have things like...that are like provenance built into the test reports; you have to say the address, etcetera of the lab. So I don't think they've thought through all the issues. We've had terrible trouble with provenance just with Masterfile information because people relabel an existing one with their own kind...like CMS will relabel something that's really produced by somebody else. So, I think it's very green, I think we should discourage its use in the next round, until it's less green.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well, I think we should encourage the dev...Clem, I would agree that it's green. I think we need to encourage it because we need it desperately, but I think we have to be cautious in expecting it to work flawlessly.

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

But how do we deal with that in the...in standardization and regulation, which is pretty absolute?

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah. You have me on that one.

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

I mean maybe trial use or something like that, but...

Calvin Beebe – Technical Specialist – Mayo Clinic

We do need to develop this, I mean...

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

I agree.

Calvin Beebe – Technical Specialist – Mayo Clinic

...and so...but so we're caught between wanting to have it used and the fear that we may just cause havoc.

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

Well ca...

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

So this is Floyd, I have a question. Is there a way to recommend, this is going to come up in the quality things, too, to recommend in a final rule that this is a future vision so that encourages use and testing, but doesn't make it codified?

Calvin Beebe – Technical Specialist – Mayo Clinic

I think that would be the right stance.

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

Yeah, I agree.

Richard Elmore – President, Strategic Initiatives – Allscripts

So the challenge is that if there isn't some sort of requirement that you're not going to have necessarily enough critical mass to move towards maturity. And so maybe Calvin in our subgroup we can consider that along with whether or not there's some minimal step in this direction that would make sense.

Calvin Beebe – Technical Specialist – Mayo Clinic

Agreed, agreed. We could further discuss this. We did put a question mark on this one because we did want to come back and talk a little bit more about this particular topic.

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

Well we have had past Meaningful Use that said exactly, this is going to be coming and it did seem to catch the eye of the industry. And I think that that's a good idea, but maybe you could find some little bitty step that would push further.

Calvin Beebe – Technical Specialist – Mayo Clinic

I think they have standards they can point to, I think the challenge is that I would not have confidence that the implementation would be absolutely uniform.

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

I think you'd have confidence that it won't be.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah. And so there's a need to have experience with those standards and have an iteration at a minimum probably. But yeah, so let's take that back as a further discussion item in our group. I think that would be very appropriate. Any other comments or questions; if not, we'll go ahead and move to the next slide.

This particular item was all about the Consolidated CDA creation performance. This was, I believe, where the gold standard reference was identified; the strategy that gold standards would be implementation of documents would be created based on data sets that were going to be used for testing to use as the way to verify the content of the documents matched the gold standard.

The comment...the couple of comments I had on this one were that I'm not opposed to the use of gold standard documents, I think they make some assumptions that a singular representation coming out of the standards is possible, and I know it's desirable, but if that's the case, I think we need to make them publically available, encouraged to be reviewed and critiqued as...if they're going to be used in any sort of meaningful way to be used as test documents to ensure that there's no optionality that is allowed that's being expressed that could cause problems.

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

Is there any reason that couldn't be done?

Calvin Beebe – Technical Specialist – Mayo Clinic

I don't know that there...oh, I'm sorry, that's not a question for us, that's really an ONC question.

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

But I mean, is...do any of them exist already? I mean, if they're still twinkles in people's eyes, it might be hard, but...

Calvin Beebe – Technical Specialist – Mayo Clinic

There's a body of examples that have been created on sections coming out of Structured Documents; I believe there's a body of over 40 sections that have been created as examples of various kinds. The problem you get into is that on a given section, what you will see sometimes is driven by the content of the data, its presence or its lack of data and so forth. So, there have to be quite a few examples. I think gold standards based on a given data set, it's an open technical question; is there a singular instance that's derived from a given data set? I hope there is, but that's not something that I think has ever been tested.

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

Yeah, and I've seen some of the examples, though not all, they're not all right or perfect.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well and that's why any gold standard has to be made right.

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

Yeah, so it's got to be reviewed.

Calvin Beebe – Technical Specialist – Mayo Clinic

It's got to be reviewed and subject to critical review.

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

Yeah.

Calvin Beebe – Technical Specialist – Mayo Clinic

So that was the first topic on gold standards. Under the (ii)(A) section, document template conformance, you know, generally think it's very applicable that if you have documents asserting that they are conformant to these templates and implementation guides, that they should be validated. Also wanted to make the point that it might be worth providing the ability for a system to prove in a structured format that the use cases involved does not produce one or more document sections.

This is going back again to the idea that we may, as we widen the scope of the health IT infrastructure that's being used, we may need to be cautious about the expectations of all sections having to be

present. And then there was a discussion a little bit about narrative documents that are processed through natural language processing and creating structure and having to be careful about the relationships that exist between the narrative and the structured content that might be present. So I think this is an area we'll maybe talk a bit more in the group about.

Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

Calvin. Calvin, I think we don't want to replicate the issue of Meaningful Use 1 where the vendors were given the option of CDA or CCR and that optionality implicitly said "and," not "or." So when we have a large menu of options, to the vendors it's going to mean "and," and so I think we need to explicitly call out the fact that we do not mean "and" when we have a laundry list of specifications.

Calvin Beebe – Technical Specialist – Mayo Clinic

So is that to the question of the various templates they're asking for and maybe trying to cut it back? Or going beyond Consolidated CDA as the solution?

Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

Well I just think that we should be clear, explicit and say that these aren't "and" that it's not a requirement to include all of this, otherwise we'll get a lot of industry pushback.

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

What were the...what's the set of this's you're looking at, I'm not following you, (6)(ii)(A)?

Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

Well this list and other lists.

Calvin Beebe – Technical Specialist – Mayo Clinic

So that's...it's...I don't disagree, I was somewhat surprised when I saw the list Chuck, of the CCD, the consult note, the history and physical, progress note, care plan, transfer summary and referral doc...referral note. All of these notes are technically documents in Consolidated CDA. Most of the industry, I think it's probably a safe assumption, is generating the CCD summary documents at the end of episodes and stays and visits. The fact that this was widened is interesting, even though they're all out of consolidated, it will mean a lot more variability in how much you have to process on the receiver side. So your point is valid in the sense that even though it's Consolidated CDA documents, they picked a bunch of them out of the standard.

Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

Well, I mean precisely, the complaint has been that we've failed in our interoperability mission because of the lack of constraint and so now you've got a larger list to further constrain or the receiver won't be able to process the data. Is that sentiment clear, Clem?

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

Well I think I hear what you're saying, I don't know what you want to do though, take this line out or do you want to...

Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

No, my recommendation would just be to constrain, to make it clear that it doesn't necessarily mean "and."

Richard Elmore – President, Strategic Initiatives – Allscripts

Just in the interest of time, I think we're getting close to running over and I know that we need public comment as well, so I'm wondering if we should sidebar this for follow up. We welcome your feedback in trying to get this one resolved. Michelle, how much more time do you think we can spend on doing the update from Calvin?

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

I guess that's up to you, I mean, maybe we could take it to 11 o'clock and cut it off there.

Richard Elmore – President, Strategic Initiatives – Allscripts

Okay.

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

We still want to have time for the small groups to get together.

Richard Elmore – President, Strategic Initiatives – Allscripts

Right, yeah, and just...I mean I want to encour...I'm not trying to discourage the dialogue, I'd just like to suggest we move that to the...

Calvin Beebe – Technical Specialist – Mayo Clinic

Richard Elmore – President, Strategic Initiatives – Allscripts

...to after the call. Yeah.

Calvin Beebe – Technical Specialist – Mayo Clinic

We could defer that. All right, as we look at then (6)(ii)(B), again this is another document type which is coming out of consolidated, discharge summary. The general question is, is it the intent that we really want to provide wider support for all the different C-CDA document types? I'll be honest, as I read through the materials, I'm thinking they want there to be only a single document generated and I can understand coming out of various use cases they could imagine it would be a different type of document and so they've picked the various different types. But I think it does get back to this other question that we were just discussing and we'll defer that.

Along that line, before we jump off this, if more than one document could actually be exchanged we might actually end up in a scenario where we may only want to require that the common clinical data set for processability be present in one and we just allow other documents to be exchanged that are created out of care. I'm implying to wanting to have greater flexibility for the exchange of documents for reading and limit and constrain the...say the CCD or a document of that sort for the purposes of data exchange. But, we'll probably have additional discussions on that and this whole topic.

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

It's a good point.

Calvin Beebe – Technical Specialist – Mayo Clinic

All right, if we move beyond this particular one, 7, go to the next slide. On the area of reconciliation, we want to enable users to reconcile the data that represents the patient's active medical...medication list, allergy list and problem list. Again, this is the question, as we widen the scope from EHR context to health IT context and try to span more use cases for the ability to exchange information, we may need to be careful about the reconciliation requirement in particular areas involving say ancillary services if we are dealing with an outsourced physical therapy activity and doing a transition document; do they actually need to do a medication reconciliation, you know? It just raises the question.

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

Well I think another problem is the problem with reconciliation, don't want to fiddle with another specialties list, I mean, there are a whole lot of issues that I don't think we've grappled with and I don't think it's really feasible the way it currently operates and how people will regard the other folks problems that are entered on the record.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah, I think Clem you hit upon one of the interesting challenges that comes up later for the care plan. Large practices have multiple lists for different specialties that are working as opposed to general lists for general practitioners.

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

Yeah, yeah and actually I've heard some physicians want each their own list, they didn't want to be fiddling with anyone else's list. But I mean this reconciliation suggests put it all together.

Calvin Beebe – Technical Specialist – Mayo Clinic

It makes assumptions as to how lists are managed within large systems.

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

Right and I think it's ignorant in that context.

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

Yeah, this is Susan Hull; I think another thing that's starting to happen is reconciliation in retail care setting, so at the retail pharmacist at Walgreens; how does that information get back into the record or with a home health nurse, you know, beyond the traditional clinic setting...

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

Well is there a way...

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

...hospital setting.

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

...to caution them about some of these things that are being required? They won't fit the model, in some cases.

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

This is Floyd just with a comment. I think the...perhaps this is something that needs a careful usability, user-centered design process to help understand the real need, because it will vary and that may be one way to try to approach understanding these things.

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

But how do we slow down the train that's got it regulated to be done, has to be done?

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

Well, that's the challenge but forcing it without definition, without clear definition is a problem.

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

This is David Dinhofer. I think this...I'm just bringing up a question whether this is a good place to also bring in patient involvement in the reconciliation? I know that several groups are working on it and so in that usability model, as it's being discussed, I think we should include how the patient might involve in reconciliation because they are really centered about...they know all the medications, for instance, that they're going through and why shouldn't they be an overseer of their own care?

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

Well I think in medications it works pretty well.

Calvin Beebe – Technical Specialist – Mayo Clinic

That definitely seems to be true in our examples here; the patient should be involved in that process.

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

But the problem list is a different set of issues because the dermatologists have a hundred names for everything and they're all Latin and I don't know if the patient knows which is what; I certainly didn't know which was what and each dermatologist called it something else and you're reluctant to knock one of them off.

Calvin Beebe – Technical Specialist – Mayo Clinic

So I think we'll bring that back to the group to talk about the widening use cases for health IT technology that are based in these standards and guidelines and if there's something cautionary...

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

Well, probably 90% of patient's reported allergies aren't really allergies, so we've got to...they may not really have it right either. There was that challenge test of...allergies...percent of them had no reaction.

Calvin Beebe – Technical Specialist – Mayo Clinic

All right. If it's all right, maybe we'll move ahead, because I want to be sensitive to the fact we're about 6 minutes to when we should try to wrap this up if we can. And incorporation of system

performance...or excuse me, moving to care plan, we agreed with the recommendation. I did want to push back a bit, the care plan as it was defined, bless our hearts in the standards organization, actually had a number of sections that were structured, meaning there are structured entries that are going to be codified for the goal observations, the health concern act and the outcome observations.

And I just wanted to challenge the question whether these actually should be required to be structured tests; I mean, there's nothing here indicating it would be tested, but as soon as you make something structured, you...processing issues if everything isn't in perfect alignment. And so I just...I was curious as to whether we really think there is a desire to go down this path with processability or should we actually ask the standards to loosen this back up and make it more narrative.

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

I would, I would loosen it up.

Calvin Beebe – Technical Specialist – Mayo Clinic

So it's...

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

It's been done mostly with narrative and I don't know if we even know the codes and it'll take people forever to record it all.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well, I mean it's a cost benefit question that I'm trying to raise.

Richard Elmore – President, Strategic Initiatives – Allscripts

Calvin, I think also as a general comment, there were a number of areas that we've been through, I don't want to go back through and identify them, where I think there's consideration as to whether or not we want to go quite as far as we've gone in Stage 3 requirements. So there was discussion at the HIT Standards Committee about whether the kitchen sink had been thrown into the Stage 3 rule and so, I think each of the groups it would be helpful to give thought to, you know, how far do we want to go to create focus for execution and success; again, so in addition to refining the particularities of each requirement or gaps that might be identified.

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

Yeah, let's take the kitchen sink out. Now the other thing I have trouble with is the concerns. I have, you know, given that the original WEDi definition of problems I think they're so overlapped are people going to really keep two lists? And if they are, how are they going to do the work and how are they going to decide which goes in which? You know, WEDi defined it as anything that had anything to do with a patient's health. So I think they're going to be confounded, confused and be double work.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well I think this is one of the challenges of referring to a standard that has the ability to model very structured data; we need to try to make sure there's a desire to actually carry that through or should we step back. But it's a good challenge that we need to look at. We're getting pretty close, I'd like to move

forward just to kind of give a survey of what we've got, because you'll probably get a chance to see the final and then comment; if we move to the next slide.

The common clinical data set updated CDA and diagnostic imaging reports; in general agreed for an EHR-to-EHR that C-CDA exchange seems like the appropriate recommendation. We did kind of fall back on these questions of other use cases involving other technologies such as transcription feeding in and so forth; whether they're...they may have some unstructured component requirements. Again, I came back and questioned the preclusion of the unstructured document IG that's found in CD...C-CDA may need the rethought as long as the content that needs to be processable is in another document. And it really kind of pushed the question, are always talking about a single document exchange or could we actually start talking about moving the documents the doctors actually create along with the summary documents? And so that the wider set of clinical documentation is available.

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

That's a good point, a very good point.

Calvin Beebe – Technical Specialist – Mayo Clinic

And then lastly, there's been a complete lack of support, as best I can determine or very limited support for any of the imaging capabilities that are supported in the base standards and we need to provide some facility for images to flow either if...either in requiring it be supported in the standards or to allow other formats to enable it. And so I think there's some clarifying language that we need to see.

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

Well along that line, even the image reports, radiology now has at least some structured codes in the C-CDA but EKGs and spirometries and the rest of them, there's no mention of them.

Calvin Beebe – Technical Specialist – Mayo Clinic

Well they've repr...they have a lot of images that we need to think about.

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

Well I mean, the image...I mean, as a general internist, I would just want to read the darn report, the image is nice sometimes, but...

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah.

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

...give me the darn report first.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah, yeah.

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

We just seem to have a blind spot, I mean, I'm for the images, too; I'm not disagreeing with what you're asking for.

Calvin Beebe – Technical Specialist – Mayo Clinic

I mean, I think we're getting very close to the end; do we have any more after this? Application access, oh, application access to the common data set we should not...this probably needs its own time. API must support...

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

Calvin, maybe we make this our stopping point...

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah.

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

...and pick up here.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah, this is a big topic unto itself.

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

Yeah.

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

Yeah.

Calvin Beebe – Technical Specialist – Mayo Clinic

So, that's kind of an overview of where we're at, at least in our current comments. I appreciate the feedback we got and we will definitely be paying attention to it and we would encourage others to continue to provide feedback to us. And I'll wrap up at this point and thank you.

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

Very nice summary, Calvin. Thank you.

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

And thank you Calvin for agreeing to lead this group and to Floyd and Kim as well for the other small groups. Rich, if you're all set, can we open up for public comment?

Richard Elmore – President, Strategic Initiatives – Allscripts

Sounds good, thank you.

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

Okay. Caitlin, can you please open the lines?

Public Comment

Caitlin Chastain – Junior Project Manager – 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.

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

So while we wait for public comment, we have another meeting next week on May 4. We'll try and be as efficient as possible; hopefully we can have materials in advance so people can review them and maybe possibly share some thoughts in advance, because I'm not sure we'll be able to get through everything. But we'll do our best. And it looks like we have no public comment. So thank you everyone and again, thank you Calvin.

Calvin Beebe – Technical Specialist – Mayo Clinic

You're welcome.

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

And we'll talk on May 4. Have a great rest of your day.

Richard Elmore – President, Strategic Initiatives – Allscripts

Thanks so much Calvin. Bye, bye.

Calvin Beebe – Technical Specialist – Mayo Clinic

Bye, bye.

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

Thank you. Bye, bye.