



Health IT Standards Committee

Final Transcript

December 10, 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. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Jon White?

P. Jonathan White, MD – Acting Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Here.

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

Hi, Jon. John Halamka?

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

I'm here.

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

Hi, John. Andy Wiesenthal? Angela Kennedy?

Angela Kennedy, EdD, MBA, RHIA – Head & Professor Health information Management – Louisiana Tech University

Here.

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

Hi, Angela.

Angela Kennedy, EdD, MBA, RHIA – Head & Professor Health information Management – Louisiana Tech University

Hello.

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

Anne Castro? Anne LeMaistre? Arien Malec?

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

Good morning.

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

Hi, Arien. Charles Romine, I think Kevin is in for him?

Kevin Brady, MS – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology

Yes, Kevin Brady.

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

Hi, Kevin. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'm here.

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

Hi, Cris. Dixie Baker?

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

I'm here.

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

Hi, Dixie. Liz Johnson? Eric Rose? Floyd Eisenberg?

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

I'm here.

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

Hi, Floyd. Jamie Ferguson?

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

Here.

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

Hi, Jamie. Jitin Asnaani?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Good morning.

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

Hi, Jitin. John Derr?

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

Here.

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

Hi, John. Josh Mandel? Keith Figlioli? Kim Nolen?

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

Hi, Michelle, I'm here.

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

Hi, Kim. Leslie Kelly Hall? Lisa Gallagher?

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Here.

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

Hi, Lisa. Lorraine Doo?

Lorraine Doo, MSWA, MPH – Senior Policy Advisor - Centers for Medicare & Medicaid Services – Health and Human Services

Here.

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

Hi, Lorraine. Nancy Orvis? I'm pretty sure I heard Nancy earlier. Patty Sengstack?

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Hi, good morning, everybody.

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

Hi, Patty. Becky Kush? Rich Elmore?

Richard Elmore, MA – President, Strategic Initiatives – Allscripts

Good morning, Michelle.

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

Hi, Rich. Steve Brown? And Wes Rishel?

Wes Rishel – Independent Consultant

Here.

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

Hi, Wes. Okay with that I will turn it over to the John's.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health

Michelle, this is Anne LeMaistre, I'm here too.

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

Hi, Anne, thank you.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Excellent, John Halamka do you mind if I roll first?

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

Please do.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you, sir. I want thank everybody for being on the phone with us today. It was wonderful to see you all back in October but it's just as nice to hear your voices. And we're looking forward to seeing you in person in January as well as we come into the New Year.

So we've got a great agenda for today. In my opening remarks I'm not going to talk a lot about the agenda ahead of us and I'll reserve, actually, you know, since it's the last meeting of the year, when we get to closing remarks I'm just going to reflect back to you, you know, some of the stuff that we've been doing over the past year.

But I figured in opening comments that we ought to have a look forward, so, you know, as we all are sad to acknowledge, but must, because its reality, after many years of dedicated committee service John Halamka will be rotating off both as a member and as committee chair after the January meeting. And, you know, we've been aware that this has been coming for a while so we've been, you know, working long and hard at ONC on our next phase of leadership for this committee which is vital, is essential and critical, and I cannot use enough words like that, for the work that we do at ONC and across, you know, the health IT sector.

So, I am very pleased to be able to tell you that you can't just replace John Halamka with one person so we are going to be welcoming two new committee co-chairs who are outstanding committee veterans Arien Malec and Lisa Gallagher will be helping lead us in the months ahead. John and I will remain co-chairs as we...through the January meeting, the joint meeting, and after that your colleagues will be taking the reins as co-chairs.

There is another change concomitant to that which I want to roll out here for you. So, for the past year it is been my great pleasure to be John's co-chair for this committee and it's been rewarding beyond my wildest dreams to be able to do that. It really has. It has been, you know, a really fun-filled year and, you know, we've done a lot and we've achieved a lot and like I said we'll talk about that later.

You know Karen and I have been doing a fair amount of talking about the role that ONC plays on the committee and, you know, we think that it is appropriate for, you know, I've been serving as the co-chair of the committee, but we think that moving ahead it is appropriate to let the committee members be the chairs and rather than me continuing on as an acting co-chair or tri-co-chair I will become an ex-officio member of the, you know, committee still coming to all the committee meetings, still, you know, sitting around the table with you all, you know, sharing meaningful glances with Arien and Lisa and the rest of you as we go along but not acting in the co-chair role. So, like I said it's been a tremendous pleasure to be able to do this and I look forward to continuing our work together. I'm just going to slightly alter that role.

So those are kind...the big announcements that I have for you. Arien and Lisa thank you so much for being willing to take on this responsibility. I know that you have, you know, the confidence of your colleagues here around the table and all of us at ONC and you're going to do a tremendous job moving ahead. So, John, I will gladly give the floor to you. After you're done you may want to give Arien and Lisa a chance to just say a few words.

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

Well, absolutely. The big question Jon is will we have batons to pass to them at the January meeting, you know, this is significant.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

You know you laugh but actually Jacob gave me a baton so I'll bring it to the January meeting.

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

Okay. Well, again, congratulations to Arien and to Lisa I think those are great choices and we will open it up for their commentary. As John said in the meeting today we have three presentations. We will go through a very interesting report from Cris Ross and Anita on the Committee on Certified Technology and often I hear "oh, well, my EHR is certified and therefore it must do everything that my practice needs and must have interoperability and it must be fit for purpose."

And I think we know that there is heterogeneity in the way that vendors implement EHRs and workflow so how do you assess whether it's good or not for a particular purpose in the specialty or PCP office? So, having a tool will really be, I think, valuable. We'll hear their thoughts on that.

Folks know that sometimes I say controversial things like you know ICD-9 and ICD-10 maybe not the best vocabularies for quality measurement and maybe we didn't get the value we wanted from ICD-10 things like that, all debatable statements but we're going to hear from Chris Chute and Floyd Eisenberg on as we charged them a few years ago with looking at the various vocabularies and transition planning as we go from current state to future state and we've allowed multiple options, should we allow multiple options in the future? And how do we get to Nirvana? How do we eliminate the burden on vendors, the burden on providers by providing these multiple choices and get to single recommendations? So I look forward to that.

And in the precision medicine update we'll hear what are the standards ready for prime time? What are the standard gaps and what are the accelerators that ONC and others can provide to reduce barriers? So I think very good topics for our last meeting of the year wrapping up work that has been started.

And I do want to comment, Jon, on some interesting press that came out over the last day or two saying that "oh, well ONC folks were at a conference and they made some comments that by 2016 everything would be interoperable with everyone for every purpose." And I think Jon for the record it's probably important to say that's not what ONC people said and so a lot of folks in the press have asked me as a co-chair "well can you comment on, you know, will the standards be ready and will all that be possible?"

So, I, you know, with Steve Posnak and Jon tried to actually understand what was said. And what they said was, you know, there are certain use cases and certain transactions such that you might imagine admission notification, an ADT message being more or less ready because it's in HL7 2.x construct and that's more or less a, you know, well adopted and secure and, you know, a known kind of thing that we often send today.

Might we, you know, by the end of 2016 have more ubiquitous transmission of admission notifications and ADT type messages across multiple parties through multiple health information exchanges because in the Dixie Baker's scale, you know, that transaction is ready for prime time, it is adopted and mature. And so, if you skinny down the statement to something like that, of course, you know, noble goal and we look forward to, as we charge forward in interoperability, taking on projects like that which are very concrete and constraint.

So Jon I don't know if you as an ONC person are allowed to make any comment in that regard but I just...since the press is going to say these things I thought it was important for the committee to clarify.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

No, I appreciate you bringing it up. The event I think that you're referring to is the, you know, Bipartisan Policy Committee event that was held earlier in the week. We actually are going to have some communication material coming out about that soon. So, I'd hate to get out in front of that, but, you know, essentially, you know, there are a lot of good things happening in interoperability.

I would love if everything was interoperable with everything else at all given times and all given places in 2016 and I think we're going to make substantial progress on that in 2016. We'll talk about the specifics of that and the communication material we've got coming. So, appreciate the chance to try to be a little bit more clear.

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

Great, well, you know as the Standards Committee we are the vanguard that talks to the press so keep us informed. Thanks.

So with that, again, I think we have minutes of November 3rd to approve so let me open up the floor. Are there any comments, editions, revisions to the November 3rd meeting minutes? Okay. Well none being heard we will adopt those by consensus. And then before we begin the Cris Ross presentation let's open up the floor to Arien and Lisa to welcome you, to thank you, and to hear your thoughts on the work ahead.

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

Thank you very much I just had that shock of horror where I realize as co-chair I'm going to have to actually read the minutes. You know I was at that BPC meeting and what struck me is that let's say five years ago I would sit back and wonder why folks didn't realize how important standards and interoperability were for the future of healthcare and it was actually very striking to me at that event that we had two sitting senators. We had Andy Slavitt, the Acting Administrator for CMS. Karen of course was at the event. We had the CEO of the largest for-profit hospital chain in the country, not for profit hospital chain rather in the country. We had the president of the largest medical society in the country and somebody who runs a large research network, as well as myself, on a panel.

And it struck me that I think we've passed the era where interoperability is this necessary but sort of hidden component to all we do and that actually now there is a good amount of attention and focus on the importance of interoperability. It's also a lesson to be careful what you wish for because it might come true.

But as we go into the next year and the next journey of the Standards Committee those are some of the things that kind of weigh on me as I take on the challenge of being the co-chair is, you know, having a renewed sense of purpose for the work that the Standards Committee does and a renewed sense of how important this journey of improving interoperability across the country is to the future of healthcare delivery system reform and the like.

So, in general just want to say, thank you to ONC for thinking my hands are in any way fit to receive the baton and I hope to have a great journey going forward and I'll obviously have more to say in the January meeting but thank you.

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

And Lisa, any other comments you would make?

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Yes, John, thank you and I'll keep it quick. First, I want to say that I'm both honored and humbled by the invitation to serve in this role but most importantly by, you know, the expertise and dedication and collective will of the members of this committee.

I believe very strongly in the importance of this committee and its role in advising the National Coordinator and, you know, I wasn't at the BPC meeting yesterday I was at a meeting on the hill, which seems like more and more frequent, so, we, you know, I agree with Arien, interoperability is now at the forefront of interesting concerns by everyone, technologists, clinicians and policy makers, so we've got a lot of work to do and I'm absolutely thrilled to take on this role, thrilled and humbled. And I can only hope to live up to the standards that by Jon White, John Halamka and other previous chairs and I look forward to working with everyone as we move forward. So, thank you, John. Thank you to both John's.

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

Well, thank you. So, well, with that let us move forward then on our agenda for today and then as Jon White said at the end of the meeting we'll comment on 2015 achievements and we will prepare for that first meeting and the handing off of the baton. So, Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Good morning, John, how are you?

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

Good.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Is Anita also on the line this morning?

Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania

I am.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Good morning, Anita. We had originally planned to have Anita be at the Policy Committee and me at Standards but I think there was a change in policy so we'll report together this morning. I'll probably lead us through it and Anita will comment along the side. Before I get started I have to withdraw my comment about Arien who, now I know who he is, you know, big-name and a big job and congratulations to him and Lisa. If we could advance the slide to the next page?

The Certified Technology Comparison Workgroup has this membership as listed. I'm really pleased to be co-leading this with Anita Somplasky from Quality Insights. And as you can see from the membership we've sought to have input from a variety of practice groups from small to large, some vendor input and some association input. And we feel like we've got a really good group. We've met a number of times already, and we'll go through that in the second, to describe our work. If we could go to the next page, please on the MACRA language?

This is our charge. It was included in the legislation passed last April in the MACRA Bill and specifically calls on the Secretary to provide a study and report on the feasibility of establishing a mechanism to compare certified EHR technology products. The particulars of that study are described in the text below that it is to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products and it lists two examples that this may include.

It may include a website with aggregated results of surveys of users and it may include information from vendors of certified products that's made publicly available in a standardized format. We are all familiar with CHPL which is one technique today that is used to provide that information in standardized format. So part of the question is what could be done to supplement or advance the work by CHPL?

And a report will come back to congress within one year, so by April of next year, from the Secretary including information on the benefits of and resources needed to develop and maintain such mechanisms.

And again, this is a study to provide some recommendations. It is not a project necessarily for the federal government to go build something. I think it's more likely that we'll be looking at private sector capabilities and where are there market failures that don't lead this to exist already today. Before I go onto the charge, Anita do you want to add anything to this?

Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania

No, I think you've covered it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, so if we can go to the next slide to the charge of the Task Force. So this is our interpretation of the legislative language that I just walked through that we are charged with providing recommendations on the benefits of and resources needed to develop and maintain a certified health IT comparison tool.

So we will identify different health IT needs for providers across the adoption and implementation spectrum and we've had some discussion on this and I think we're still at the point where the Task Force is providing more input. I've gotten some off-line comments since our last meetings on this topic.

But we believe there's a particular focus on providers with limited resources and/or lower adoption models. That doesn't mean that we would exclude other sectors but we want to emphasize the area where the need is most acute.

Second, identify user needs for a comparison tool. It's no good to try to build something that users won't use. One of our Task Force members, Liz Johnson, forwarded a little news article today in which someone said, you know, Yelp for EHR has been needed for a long time maybe this will help advance things.

So the question is in a product and consumer friendly way what is it that people really want and what do they really need? What will be most helpful to them to make the right choices for them around the acquisition and use of EHR tools?

And then finally, identify gaps in the current tool marketplace and barriers to addressing those gaps. So, you know, the provocative question that we want to raise is clearly there are lots of places where agencies and groups step into the void and provide advisory services to consumers around how they should select and use tools or technologies and you can think of many of them I don't want to list them because by inclusion I'll exclude someone's important company name or brand name.

But we want to identify, you know, why is that insufficient? Why isn't the market solving this problem themselves? And if there is a market failure where can government step in to advance the cause? So that is our charge. If we can go to the next slide, please?

Here's our work plan. So we've met a number of times already to get organized. We're providing step number four draft recommendations to the Standards Committee today and then we'll be meeting through December and January with our goal to provide final recommendations to the joint meeting of the Policy and Standards Committees on January 20th. Along the way we'll have two virtual hearings and the meat of the rest the presentation will be to discuss what those hearings will include in the form of panels and questions to be asked. If you can advance to the next slide, please?

So here are the five panels to be proposed on January 7th and 15th. You can see how we are intending to organize this around primary care providers, around specialists, around certified health IT developers, around those vendors who provide health IT comparison and information tools today, and to look at quality improvement and alternative payment model capabilities. We identified that as a future facing need that these tools will not only need to address, you know, Stage 1, 2, 3 requirements but when we look within 1, 2, 3 to the future quality improvement and APM is a significant issue and we want to make sure we keep track of that.

So, I think before we go into the specific panels and I do want to walk through them briefly because we're going to solicit your comments and input. I think I want to pause here to see if Anita has any additional comments or if people have any questions or comments about the composition of the panels themselves. So I'd turn first to Anita?

Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania

Thanks, Cris, I just did want to point out we had a lot of discussion about whether or not to include alternative payment models but felt that it really was necessary given the challenges that we heard from folks trying to do some of the population management with the current state of EHRs and really thought that...and for reporting purposes that they already have for quality improvement initiatives. So we did feel that even though it's future state that this was really important to have a panel to discuss.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Jon and John I think...I would like to pause here just a little bit to get feedback on the panels and compositions and then reserve some time to walk through the questions as well. So, I wonder if we could just go to Q&A and comments now.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Absolutely.

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

Absolutely.

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

Hi, Cris, this is Jamie my hand is up.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well Jamie let's call you first.

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

Okay. So, on the construction of the panels I think it's important for the provider panels one and two to consider input from integrated multispecialty medical practices in both cases as well as sort of purpose specific practices because I think that primary care providers who operate in a multispecialty world may have important differences in their perspectives and requirements similarly, specialists in the multispecialty setting which may have primary care actually in the same group practice also would have different perspectives and requirements. So, I think obviously you want to get the small office kind of providers. And I don't want to confuse this with the size of the medical group it's about the multispecialty nature is really what I'm commenting on.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Jamie it's an excellent point and we'll take that feedback. Thank you.

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

Other questions?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Or comments?

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

This is Arien, I wonder whether...although the focus was spawned by MACRA and is therefore provider focused, whether it would be reasonable to collect input from hospitals and long-term post-acute care who might also be the users of the more general functionality?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, the comment about hospitals has been raised subsequent to us putting these slides together by some Task Force members Arien and I think we'll need to take that into account.

We had some discussion about consumers of these tools or users of these tools that are not Meaningful Use qualified, so post-acute care would be a logical extension. I think we'll take that strongly into advisement. We are a little bit under crush of time around scope but the comment is a good one. So we'll include that in our considerations.

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

All right, thanks.

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

So...

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

Cris, this is Michelle, just for what it is worth, there is somebody that we've invited that is from the post-acute care sector.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well done, Michelle.

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

This is Eric Rose, I think the idea is really intriguing and will really have the most value if it's not limited to just certified EHR technology. I think Yelp for EHRs would have been a great idea like six years ago when everybody was rushing to get an EHR but given the penetration of EHRs and physician practices and hospitals today I think even more valued today might be Yelp for population management too, Yelp for laboratory information systems, Yelp for telemedicine technologies and so I encourage you to think much more broadly than just certified EHR technology.

The other thing I want to propose is that ONC may be in a position to pull a lever policy-wise that would have a big impact here which is that most customers of EHRs are prevented from sharing certain information about the EHR too liberally like screenshots or video captures and what it's like to use the EHR and if you really want to enable a community that talks about "hey what it is like to do X in your system?" "Well, it's easy here you go, here's what it looks like." "What's it like to do X in your system?" "Oh, it's really difficult here's what it looks like." A lot of time you can't do that today under your agreement with your EHR vendor.

So, if ONC said, you know, EHR vendors cannot forbid their customers from sharing screenshots or something like that. Obviously there's some complexity around there. The EHR vendors might say "well, geez, we want the ability to respond if somebody misrepresents our application" or whatever, but that's actually a really big hindrance I think to effective communication between users of these systems about, you know, what the experience is while using them.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah that's a very...to go in reverse order I think that's a really good point. You notice that one of the mechanisms that were on the study charge was this idea of a website with aggregated results of surveys of Meaningful EHR Users on functionality. And, you know, you could imagine that in the context of, you know, that kind of mechanism that sort of, you know, sharing of information amongst peers could be very powerful.

You do raise the sort of legal questions around what authority or power, or influence does the federal government have to step into private contracts between vendors and providers? You know I'm not taking an opinion on that other than to note that it's sort of a gnarly topic from a legal perspective but your point is a good one.

On the original one, Eric, you know, our charge says that we have to focus on certified EHR technologies. It doesn't say that we can't look at some other things. I think if we do a good job on the certified EHR technology discussion and comments it would certainly be possible to extend it into some of the other kinds of areas you described.

And again, our goal is not to have a Task Force that will result in necessarily the federal government building and maintaining a website or comparison tool. The goal is to figure out how to help foster and encourage the development of such tools or perhaps more likely by private interests.

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

Cris, this is Dixie, could I...I don't know how to raise my hand so...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

This is working just go for it.

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

Oh, okay. I know this is a huge task just to look at the needs of providers across the spectrum of locations and the availability of resources and specialties, etcetera. But I do think that the burden on providers to provide their data, make their data available to what has traditionally been called secondary users of the data is increasing day-to-day right now...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

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

Especially researchers and outcomes, as you mentioned, outcomes measurement people but also patients and payers and there's a whole spectrum of consumers of data, if you will, that getting these people those data can be very burdensome to providers.

So I think that from maintaining the provider perspective that it would be good for this task to look at the burden that is placed on providers in making their data available to these secondary users.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's a great point, Dixie. We had a little bit of conversation about things like submission of data for public health which is a particular subclass of what you just described but I think that broader question is a really good one. It also strongly relates to the quality component that we listed and I know Anita has a particularly acute interest in that. So, great point.

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

Thank you.

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

Cris, this is Andy Wiesenthal, I too am not in a position to raise my hand so if it's okay I'd like to make one comment about this, I appreciate the work by the way it's very nicely presented, and that is that it's going to be important if you can structure questions that will help you distinguish between people who are saying that they cannot accomplish their work exactly the way they used to and functionality that's truly missing in a sense that, you know, you should be able to accomplish your work in a different way that might actually be better for patients. Do you see what I'm saying?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, yeah.

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

I'm used to this, I've had these discussions with doctors for more than a decade and very often it is, you know, you've made it impossible for me to do my work and when you get underneath the covers it's "I can't do it the way I always did it" not it's not possible to achieve the desired clinical outcome or process outcome. "I have to learn a new way and I don't want to."

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Believe me, I have those conversations daily so I completely relate to the distinction that you're making. It's a very good one. Absolutely.

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

So, structure questions that ask them to really separate that out as they're testifying and describing the issues would be very important.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I think that's right, Andy and thanks for the comments. I think a related or maybe even superset of questions is there's a lot of concern and frustration amongst users around...that EHRs have made my job impossible, let's just, you know, throw out a quote...

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

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

When in fact it's, you know, the nature of the work is also changing at the same time and sometimes it's really difficult to tease apart, you know, what has changed in the practice of medicine at the same time that, you know, there's been new changes in regulation and requirements for data gathering, you know, new rules around payment models, you know, all those kinds of things are changing simultaneously and it's sometimes difficult to discern exactly what's what.

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

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You know I was really pleased that Steve Stack from AMA was willing to join us on the Task Force. I know their organization has done some work. I served on one Task Force convened by AMA that got to the issue about provider dissatisfaction with technologies and that Task Force I thought did a nice job of teasing out the question that you just...or the issue that you just raised and I hope we can bring that same discernment to this work. It's a great point.

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

Good, thank you.

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

Cris, Rich Elmore has a question.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hi, Rich.

Richard Elmore, MA – President, Strategic Initiatives – Allscripts

Hi, Cris, hi, first of all thanks. This is so important I think for consumer protection and just really making more transparent, you know, the work that's...the products that are available to the community.

A question for you is obviously when you make these decisions, a purchase decision there's a lot more that goes into it than functionality and I was wondering how your team was thinking about, you know, what's the scope of the comparison that you're considering?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well for example we had a relatively robust conversation on cost information and the obvious need that consumers would want to have some guidance about what's the true lifecycle cost of these products? And how does that relate to the ability of providers even if they wanted to provide complete price transparency to give actual...you know active guidance to consumers? And we'll go back and forth and back and forth on that but these are not simple commodity purchases. This is not like buying a refrigerator, this is buying, you know, a complex set of products and services often times especially as you get to more complicated practices.

So, we looked at the cost issue. We looked at usability issues. We've had some discussion about how do we provide information about the characteristics of the vendor themselves that might indicate things like longevity in the market or, you know, future plans those kinds of things.

We've learned a lot or we're hoping to learn a lot from the regional extension center experience. Again, my able co-chair, Anita, has deep experience in that space, so, you know, what worked and what didn't work as the RECs were trying to provide useful information in this space.

You know I wish that we had a much longer period of time and ability to do panels in much more depth and more time to do discernment. We're on a little bit of a fast track so I want to set some expectations that are recommendations are, you know, going to be constrained by time. But your point is a good one, you know, I think we want to cast as wide a net as possible.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Hi, this is Patty Sengstack, just a quick question. So, you mentioned that you were going to use the categories of cost, initial and ongoing, which is fabulous, thank you, and usability. Will you be sharing with us the other categories that you're going to include before a final draft comes out?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well we'll provide a report back to the joint committee in January. Subsequent to that ONC will be developing the results of the study. I would turn to probably ONC staff to give their thoughts about how they might bring back drafts of that report, you know, subsequent to the January meeting. I'd also say we raised cost as a discussion item. I don't want to create an expectation that we have determined yet that we can include the cost categories that we just discussed. It's an area for exploration.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Yes...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think our goal is to try to provide the highest amount of signal and the least amount of noise wherever possible and, you know, if there is a category where we don't think that, you know, providing a comparison tool will provide an accurate viewpoint, you know, there's the possible effect of oversteer providing some sort of advisory tool or guidance tool or whatever that is in fact misleading by inaccurate precision. So anyway I don't want to prejudge what we can and can't do we're still in the early days of that...

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Yeah and...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But I would turn to ONC. I don't know if Dawn is on the line who is the staff person leading this or Michelle might want to comment but after we do the report to the Standards Committee and Policy Committee will there be additional circulation of the materials before it's submitted to congress?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

It's Jon White I don't know if any of my colleagues are on.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hi, Jon.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Hi, I don't know if any of my colleagues are on the phone, if they are, you know, they'll tell me if I get it wrong.

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

I believe Dawn is on.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Oh, hey, Dawn, all right, go for it.

Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology

Okay, so because we have a deadline to congress of April, this is Dawn everyone, the timeline is very short and getting it through HHS is a lengthy or potentially lengthy process so we are hoping to have a draft done by the end of January, shortly after the recommendations from this Task Force are presented.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, that's basically what I was going to say is that we've got to go through a clearance process...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sure.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Where our colleagues have to clear it so that draft will be written, like Dawn said, hopefully by the end of January and be submitted in order to make it to congress in time in April through clearance.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Thank you.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, I think...I'm looking at the clock and we have only one minute left. I guess my request on behalf of Anita and I would be if members of the committee could look at the slides related to the questions associated with these panels and provide us feedback that you could provide via e-mail to Anita or me, or to Michelle. Michelle if you're willing to route that around to us that would be great.

Any comments about the panels as constituted and the questions that we intend to ask would be very helpful. The feedback today has been great. So, before we close, Anita is there anything I've forgotten or any points you want to amplify?

Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania

Cris, as always, you pretty much dotted all the I's and crossed all the T's. I do just want to emphasize we've had exhaustive discussions about some of the functionality, to go back to several of the comments, we've discussed the need for being able to show what that workflow looks like and how you capture that for a comparison tool so that it's not just telling...a few comments ago, yes, the work is going to change its not going to be the same old way but that folks have a way to compare just how painful the change could be to be able to create these reports.

And we've had tremendous discussions about the various reports whether it's related to population health trying to do exchange of information and trying to get to what is really needed, you know, something as simple as, or not so simple, but the audits that were done by CMS for Meaningful Use attestors that was where we saw vendors really needing to be able to provide publicly what their screenshots were going to look like because that's what was required for the DoD when they were doing the audit. So we are looking at all of those and addressing it as best we can on the extremely short timeline that we have.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Hi, this is Patty Sengstack, I'm sorry; I have one more quick question for you about the panels because I'm just looking over them. What panel would include the people that are currently doing the building of these systems in the organizations themselves? So I'm thinking about, you know, there's about 8000 nurse informaticists that are out there building these systems and probably have a wealth of information to help with this. What panel would our clinical informaticists serve on or help provide input in, what...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That is a great question. Probably...well panel one or two would be the most logical place to do it. I think it's totally fair. We want to make sure we represent the full viewpoint from end-user, IT and informaticists, those are at least three categories within those spaces.

Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology

Cris, this is Dawn...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So that's a good catch. If you've even got some suggestions about some informaticists that would be great.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

I do, I do.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Actually...

Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology

This is...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I come...go ahead.

Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology

This is Dawn, we do have...we've invited a nursing informaticist for panel one.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Perfect.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System

Excellent, thank you.

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

Okay. Well I think Michelle we are at time and great discussion and I look forward to the continued work and hearing in January about the results of your panels.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thank you, John.

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

And next we have up Chris Chute and Floyd Eisenberg and just as a highlight to the committee we do need to approve their recommendations so as you listen recognize that at the end of that presentation we are going to try seek a consensus recommendation to forward those recommendations to ONC. So, Chris and Floyd?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Thank you I'll start out, and a pleasure be back and with you all if only virtually, and then Floyd will take over for the recommendations. Next slide, please?

We had, as part of our working group, a really dedicated and engaged group of individuals. I cannot commend them highly enough. We worked over a very short period of about a month and half and enabled the creation of the recommendations that we finally had, but I do want to commend effusively the members of this Task Force who worked really quite hard. Next slide.

Our charge, as you probably know, was really the question around transitional vocabularies and transitional vocabularies you may remember are those that were approved in Meaningful Use as effectively alternatives recognizing the pragmatic reality of transitioning to a vocabulary that for the significant part were not actually used yet in care provision and the care process.

So the question was, you know, is it time to consider an elimination schedule for these vocabularies in the context of data elements and metrics for quality improvement that are a large component of Meaningful Use per se. It has, as you see, a number of secondary questions, which I think we will address in our recommendations.

It made assumptions, as you know, and that is to make any sort of meaningful planning both providers and vendors really need to understand if there's going to be a change in the association of alternative vocabularies or traditional vocabularies so that these can be accommodated in their development plans moving forward. Next slide.

So, I just want to summarize some of the underlying assumptions and discussion that the committee engaged in and I'll leave it to Floyd really to present the recommendations as such. We recognize that many terminologies, CPT was a good example, are actually starting to become considerably more sophisticated. The AMA is in the process of actually creating an ontological framework to underpin CPT and furthermore to link that framework with SNOMED so that if we think about granular coding of clinical information in an ideal state where the elements of the record are coded in detail using SNOMED concepts then conceptually it becomes possible to really generate the appropriate CPT codes algorithmically derived from the underlying SNOMED coding that's the principle. And you can see in the second point there that they are focusing on complementary coding of procedures.

I should disclose, for those that did not know, in point three I chair the ICD-11 development process at the World Health Organization and can say with some authority that we've been working with IHTSDO or the SNOMED community since 2010 when WHO and IHTSDO signed a memorandum of agreement and again the principle is somewhat the same. In the context of ICD-11 it's to provide semantic anchoring of that content but more pertinently it will facilitate algorithmic mapping from granularly encoded clinical data ideally in SNOMED to the larger aggregations if you think of ICD as a group of categories into which you can assemble persons and patients in a rollup kind of fashion than that's the philosophy as we move forward.

And then of course the fourth point is that it's improbable that a single coding system can or should accommodate all anticipated needs. For example it's improbable that LOINC and RxNorm would be entirely supplanted by SNOMED although we do recognize the partnership between SNOMED and LOINC particularly in the space of laboratory names. Next slide, please.

The aspiration was that this aggregation process could be a kettle of fish if we're not very thoughtful about it and so the question was raised of whether these aggregation logics, as some people like to call them, these ways of assembling SNOMED codes into an aggregated CPT or an aggregated ICD would have a canonical framework and whether indeed the federal process might publish those algorithms and make them available in a central place so that there's no ambiguity about how these aggregations, and frankly the underlying definitions of CPT codes and ICD codes, would actually look.

And then the final point in the context of our deliberations was a realistic recognition that, you know, you can't get blood from a stone. If all you have are high-level categorical elements such as ICD codes it is not realistic to think about a reverse mapping into SNOMED codes in most instances because SNOMED is a much more granular and detailed representation and once you transform a compilation of SNOMED codes into an ICD rubric it's a lossy transform you can't get that detail back and ICD rubrics are large classification spaces with a fair degree of heterogeneity within them that's by design. It is a classification, a categorization, and to say what the detailed breakdown of clinical information is from a group of persons or patients within a given ICD code is probably unrealistic. And to say that we should have reverse mappings is I think ignoring the reality that we're confronted with a lossy transform and cannot get that underlying information back. With that I'll pass to my colleague Floyd who is going to summarize our recommendations.

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

Thank you very much, Chris, and what I'll do is I'll be...this is starting on slide five. We spent some time with the wording of these draft recommendations so I'll be reading rather than giving commentary as I go through these. So the first is we support the original intention of the HIT Standards Committee to migrate towards encoding data to primarily support evidence-based patient care, clinical decision support and clinical workflow rather than administrative activities.

Second is we also believe the coding will better support a broad array of functions including evidence-based clinical care, clinical decision support, clinical workflow, quality measurement, research and reimbursement. All of these were actually intended to address what some call secondary use but we wanted to highlight specifically what we meant by that. Next slide.

Number three, the recommendation is that the federal government should choose a date in the future to transition to clinically focused data capture and away from the support for multiple code systems for a single type of data. Thus the Task Force ultimately supports one mandated reporting and exchange vocabulary for each category of data.

Even after migration to a single terminology for clinical data hybrid measures could still continue to intentionally incorporate and combine clinical and administrative terminologies. As an example EHR data and claim reports, but to use administrative data the use should be specified and deliberate. The next slide?

It will be acceptable to use federally permitted deconstructions of other codes into SNOMED expressions and to define deconstruction it is a representation of a complex pre-coordinated expression with a set of simple coded statements such that when the set is interpreted as a post coordinated expression the set renders the same meaning. So, to do this we recommend the use of intentional value sets should be encouraged that is where members of the set are self-defining under the SNOMED hierarchies and relationship models.

The use of post coordinated SNOMED expressions should be encouraged for secondary use cases but not for primary data capture. A SNOMED expression library could in the future support exchange of complex ideas with a single identifier such as a pre-coordinated expression but without a technical...but such a technical solution is not yet available in exchange standards. The CPT and ICD-11 models may also support this approach coordinated with SNOMED in the future. And next slide.

Finally, given those recommendations, transitional or alternative vocabularies will continue to be used for reporting an exchange until a single data specific terminology is identified and incorporated into standards and programs. And this is a significant discussion of whether these should be called transitional or really alternative terminologies or vocabularies until such time as a single terminology is identified. Most of the members of the team preferred alternative. So those are the recommendations.

I can go onto the responses to the secondary questions but it may be helpful first to get comments on the recommendations from the group.

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

Very good, well, Michelle...

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

Arien Malec has a question, sorry, John.

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

Yes, I was just going to say, Michelle, do you have a queue?

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

Yes, Arien is in the queue.

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

Yes, Arien, please go ahead?

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

Michelle, is clearly jumping to it.

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

Yes.

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

So, first of all, thanks, this is obviously a very deep topic and a lot of great work has gone in here. When I'm reading over these recommendations I think the question in my head is who is being recommended and to do what?

Is this a recommendation to ONC to take on some governance work with IHTSDO and AMA and the other stewards of these terminology systems?

Is this a recommendation to federal providers like DoD and VA to implement these alternative coding schemes? Who more specifically is recommended to be doing what?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Well let me take a crack at that, this is Chris Chute, I think the intention was that ONC in its coordinating role, and that's what the "c" stands for, would assemble communities and teams, and processes that would achieve these kinds of things.

It is improbable that ONC could or should actually conduct the work independently but whether in fact other federal agencies are partnered, other public/private partnership, academic partnerships are incorporated as a way, and I might add additionally, standards development organizations, because we all know that for example in the FHIR development activities and the binding of value sets to FHIR resources there's a fair degree of sophistication in the efforts to really deal with precisely these kinds of challenges and aggregations.

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

Okay.

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

So I think the answer, it was deliberately vague in the recommendations, but I think the implicit answer was that we would prevail upon ONC to begin a coordination process of the community to achieve these goals.

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

Thank you, yes, so we're recommending that ONC convene a group with providers, developers, standards bodies and federal providers to develop and prototype these solutions?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Yes.

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

Okay, thanks.

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

Okay. Michelle how is that queue?

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

Hi, this is...

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

Sorry, there is no one else in the queue.

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

Hi, this is Jamie, I...

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

Yes, Jamie was that you?

Wes Rishel – Independent Consultant

Whoa.

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

Sorry, I just couldn't raise my hand on line but I guess I'm in the queue. So, first of all, I want to support these recommendations and commend the Task Force for all this work. Obviously a lot of thought has gone into this.

Just a couple things to mention, one is that cross maps from the US edition of SNOMED to the administrative classification system such as ICD-10 CM or 10 PCS, or CPT are already published by the National Library of Medicine today and they are freely available for use in the United States. And so NLM within the NIH is our publisher of the US edition of SNOMED because they hold our national release center in the NLM. So, just a comment and fully support the work. Thank you.

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Yes, it was remiss of me not to mention those. Thank you, Jamie those are actually crucially important resources. However, I think our intentions in the recommendation is to go slightly beyond code to code mapping efforts which is primarily what these code trans-mapping resources at NLM and elsewhere comprise into more aggregations of codes that as a cluster would map to a particular ICD code.

For example, distinguishing preeclampsia or hypertension in pregnancy from ordinary hypertension clearly requires a cluster of the fact that, one you're dealing with a woman, two there is associated hypertension, three there may or may not be hyperosmolar urine, I mean, the usual diagnostic categorizations, and of course the woman is pregnant, to disambiguate those kinds of representations and the simple code to code maps that for the most part make of these translation tables do not really accommodate that kind of aggregation logic yet.

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

Yeah, just respond to that, so Chris of course you're absolutely right about that and I agree completely about, you know, the future direction and the desired future state. I think though that because the relatively comprehensive and complete code system mappings are available today, I think that means that the nature of the transition in setting the timelines doesn't have to be held up, in my view, by any delays in the development of the algorithmic methods for that kind of aggregation.

In other words, you know, we could really start the transition timetable more quickly using the existing code system mappings and then later on as the algorithmic methods and new systems like ICD-11 come on line, you know, put those into the framework but I don't think the transition needs to be delayed because we do have maps or cross maps that are published today that are free for use and they're authoritative from the NLM.

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

Well, this is Floyd, I think the group did discuss potential timelines but was not able to actually come up with what might be the best timeline. It was discussed that because the industry has just recently transitioned to ICD-10 for administrative coding and that was a large effort the effort would be significantly large and there should be considerable time to require that all of these other terminologies would not be used for clinical documentation. We've talked somewhere upward toward 10 years but we didn't come up with a definite answer.

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

The implication of one of our recommendations that clinical information be coded in a granular rendering, presumably SNOMED, I think is an industry paradigm shifting concept. Vast numbers of electronic records today do not code at the granular level that I think we are implying. And that is why our notion of...time was I think by some reviews generous but if you think of the implications and how difficult it would be to have every provider and vendor transition to a granularly clinically encoded space that would require time.

Further, it would require time if we were not in the process to burden clinicians with the tedium of yet more structured data that they had to code. We know that this is not a scalable or an endurable process. We'll clearly need more sophisticated natural processing technologies, parsing technologies and the like to assign these codes ideally with clinician validation. But to expect clinicians to code this at a granular level in the course of their documentation I think was, at least within the framework of our discussions, a nonstarter.

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

This is Michelle.

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

So...

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

We do have a couple of folks in the queue, sorry Jamie.

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

Sorry, go ahead.

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

We have Wes and Anne LeMaistre.

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

Okay. Wes?

Wes Rishel – Independent Consultant

So my ultimate participating meeting I have finally learned that it doesn't work just to click on the little guy with his hand raised.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

All this time we've been keeping you quiet with that Wes.

Wes Rishel – Independent Consultant

That's it.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Oh, and you learned, okay.

Wes Rishel – Independent Consultant

You actually have to click on the little arrow. I have two notes here ONC and NOC. For ONC you mean after all these years the "c" in ONC doesn't stand for Czar? I thought that's what it was.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yet.

Wes Rishel – Independent Consultant

The NOC, not otherwise classified, I think Chris has alluded to the underlying systematic problems associated with the difference between a categorization and a sort of a bottom-up structure such as SNOMED and this group is presenting a terrific vision for how we could somehow pre-cluster all the specific...pre-coordinate the specific combinations of SNOMED that would add up to an administrative category. I'm interested to know if there is any proof or any plans to get proof under way that that's feasible particularly since NOC has been a way to foreshorten discussion in creating administrative codes and we don't have to worry about all the details.

As I look at this and I consider the fee-for-service system that currently still is a major factor in payment, may be less so in the timeframe of this effort, but things do move slowly, I would see this as being almost as big of an impact as ICD-10 was and that impact could be foreshortened if this algorithmic approach were shown to work and to meet the needs of the payers who I didn't actually hear as a participant in the project but, you know, I think we should approach this like other major paradigm shifts, to use Chris's term, with the representation of everyone who would be impacted for fear of hitting unexpected roadblocks down the path. Thanks.

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

And Wes very quickly to follow-up on that and I raise this because I'm actually just ignorant, if we, for example say that certain organizations have today transitional vocabularies that are profit centers and we recommend in the future that we use in sort of Jamie's term cross maps that are free, open source standards that are widely available within the US either that's because they've been provided at no cost or purchased and subsidized for us, are there going to be entities that get very mad at us because we've eliminated their profit center.

Wes Rishel – Independent Consultant

Well you raise probably the most pragmatic point John and pleading ignorance really doesn't help, nobody believes you.

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

So, I mean again, I certainly defer to the Task Force to the workgroup if there is a change management strategy so that, as you suggest, the direction is correct and how do we ensure the trajectory is as smooth as possible.

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

I don't think we got into that level of detail in our recommendations, John, I don't think that was our charge. It was really addressing the high-level question of transitional vocabularies and what should a strategy be.

I agree that as a consequence the recommendations are, how do we phrase this, somewhat underspecified. I don't deny that but we didn't see that as within our scope within a six week period to address at that level of detail.

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

Right, and completely understand. So, I think, Wes, thanks for raising these points because as we get to implementation of these recommendations those will be salient. Now Michelle did you say there were somebody else in the queue?

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

Yeah, Anne LeMaistre.

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

Anne?

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health

Thanks John. Let me just first start off by commending the work and endorsing your recommendations. I think as part of the discussion that just happened some of my points have been verbalized. But so I agree with the point on provider burden. I think we need to keep that front and center.

I also agree with your comments Floyd on timeline considerations and the need for very crucial and thoughtful implementation approach and John just kind of beat me to the punch on the change management and communication. I think that needs to be very thoughtful and I gathered from your comments that the workgroup didn't get quite that far on a recommendation on how to approach that.

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

So that is correct, we didn't see all of the implementation as part of our charge. We saw our charge as recommending...the original charge was really can we eliminate the transitional vocabularies, rewording it and the answer is, no, not now but we did give recommendations of how to move forward but not all of the change management issues, agreed. I think the convening discussion that happened during this discussion having ONC convene is a good next step approach.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health

I'm in full agreement. Thank you.

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

This is Eric Rose I'm joining by phone so I can't raise my hand except physically but I don't think you can see me from there.

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

Eric, please go ahead.

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

So first of all, thanks for this very thoughtful and I think important work that's just going in the right direction. Chris, you referred to SNOMED as I think granular or highly granular and the thing of it is, is that SNOMED runs the gamut between very fine-grained concepts and very coarsely grained concepts and if the idea is that clinicians will interact with SNOMED and then something under the hood will drive the classification coding system codes like ICD-10 CM and CPT-4 from that, the problem is that in many cases those systems are more granular than what the user might select or more granular than anything in SNOMED. Like for example, excising of skin lesions in CPT-4 the codes are broken down by the size of the lesion and that's not reflected in pre-coordinated SNOMED concepts for that.

So do you have a way to handle the one to many relationships between a term that a user might select in an EHR system and the underlying administrative classification code sets that would need to be derived?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Well, at the risk of betraying that I'm actually an academic I'll refer to the phenotyping what's called high throughput clinical phenotyping work that emerged in the eMERGE consortium out of NHGRI and that really is sort of the next generation's sophistication of how one would look at these aggregation logics specifically. The phenotyping logics involve laboratory data, medication data, obviously diagnostic assertions, natural language processing of concepts, demographics. In your example it would be obvious that you'd want to parse an op report to get the dimensional components. These are things that clinicians should not do.

We don't want people to have to go in and gather up all this data in a very tedious fashion to generate the correct code. These are things that are imminently machinable and are being machined in NIH programs and grants and indeed it's being proposed for the Precision Medicine Initiative, which I understand is your next topic.

That being said, I would characterize the infrastructure to do these as still research grade. I mean Wes was saying, can you show us how this works and the honest answer is, well, yeah in prototype, in research use cases and context to make this bulletproof production grade invisible, transparent and reliable under the hood there's a fair degree of development yet, on the part of mostly vendors I presume, to deliver this kind of infrastructure in a reliable way and that's why we were knocking around the timeframe on the order of a decade in our Task Force acknowledging that this kind of technology is not yet ready for prime time.

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

Well, I think this is more than a trivial stumbling block to the success of this effort which I support but I think you can't rely on yet to be invented NLP to solve the problem that the doctor says...

Multiple speakers

I took a mole off the forehead and...

Multiple speakers

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Hey, cogent comment, somebody is not on mute so if you could take it off please.

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

So, today you have a doctor who takes a mole off a patient's forehead and has to, as part of the workflow for documenting that procedure, has to find the gosh darn CPT code to document the gosh darn procedure and sweats and grunts, and curses, but ultimately realizes that they have to select, you know, whether it was 1 to 3 cm or 4 to 6 cm yada, yada, yada.

If you let that doctor...if you provide the doctor the sweet workflow of just saying "I took a mole off the patient's forehead" somehow using a lovely CPT, sorry SNOMED code for that or a term derived from it, then you're going to have the biller come chasing the doctor down in the middle of her clinic day to say how big was that because you didn't happen to document it and, you know, the medical record says...what I'm saying is that these are real-world nontrivial disruptions that have to be thought about while this sort of grand scheme unfolds.

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine
Agreed.

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

So, Eric, this is Floyd, just with a comment on that, I think SNOMED was not intended to go as deep as the exact size but using decision-support or other mechanisms for data entry the doctor is entering, using your example, what was done and to be sure that the size was included in that, by just documenting the size the physician wouldn't need to identify which CPT code the system should be able to do that and I think that's what we're trying to drive to.

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

Yeah.

Wes Rishel – Independent Consultant

This is Wes; can I get back in line?

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

Sure, so was there further comments from either Chris or Floyd on that or should we turn back to Wes?

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

No, no I'll let it go. I think I made my point.

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

Okay, Wes?

Wes Rishel – Independent Consultant

Yeah, I think the point is really important partly for my understanding of it, it's the first time anybody ever talked about a one to many relationship between a SNOMED utterance and the administrative codes for the action. I always was thought of it as...the SNOMED codes as categorizing...I'm sorry the administrative codes as categorizing multiple SNOMED codes.

So, it raises the issue of what data is being collected in order to get paid versus what data is being collected in order to treat the patient, derive knowledge from the aggregation of the information we've collected treating patients and so forth.

The way I understand this now, if it will work it will work because someone with suitable authority sets down to the payers that in order to require a concept for billing you have to demonstrate a way to construct it algorithmically from data that is collected clinically. I think that this would be an enormous step forward or another step forward would be changing the requirement on who keeps track of things administratively closer to the provider, but fundamentally, I would say that my view is that this is a great vision.

We need to do the necessary work to convince someone in authority that, and there's only one group that I can think of that has that kind of authority, that it's feasible even to continue to investigate it. I wouldn't want to set this aside but I do think I have a clearer understanding now of why Chris is emphasizing the amount of work yet to be done.

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

Thank you. So, Michelle...

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

This is Jamie, can I get back in line also?

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

Well, exactly what I was asking. So, Jamie, please go ahead?

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

Okay, thanks. So, I appreciate the points that have just been raised. I would also point out that there are, in fact today, many tens of thousands of physicians who do capture a large majority, generally I think over 98%, of their records data capture using the US edition of SNOMED and so all of these problems are now being dealt with, you know, in practical applications that could be reviewed and you could actually talk to them and find out how they deal with these few exceptions that you're talking about.

I would also note that as regards to the long timeframe for development that's a long timeframe for development for the algorithmic automated mapping for algorithmic aggregation whereas if you use the simpler code system mappings that are already available, that are already in use, that providers are already coding in, the payers are already getting paid on today, in fact, I believe the timeline could substantially be accelerated while not keeping...not taking your eyes off the prize of the long-term vision of these algorithmic methods, you know, and I completely agree that's a long way off, but I just don't agree that we can't start now.

Wes Rishel – Independent Consultant

This is just Wes, I just want to say if we can substantiate that 98% number that Jamie quoted then that is a major, major insight that he has just provided. I think it definitely shapes or reshapes my vision of this.

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

So, Chris, Floyd, any comments?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

I think everything that has been said is right on and, you know, how this is staged or phased, or implemented we did not presume to detail. We sought as our effort to answer the question and chose to make something of a provocative visionary component to our recommendations.

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

Very good. Well based on all the discussion so far...and Michelle is the queue empty at this point?

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

It is empty.

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

It seems as if we've had a lot of commentary in support of your proposal but we've not had any material revisions to it, again, sort of thinking that we have to get a set of recommendations to ONC in the form of a letter. So Chris and Floyd, I mean, based on your parsing of what has been said did you think there was anything that needed to be restated or revised, or clarified?

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

So, I just question where the Task Force did not recommend specifically the next actions except for selecting a date in the future. So perhaps from the discussion of the committee that ONC uses convening function to establish the path to get there would be something the committee might want to add to this?

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

And Chris, is that reasonable?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Bloomberg Distinguished Professor of Health Informatics – Johns Hopkins University; Chief Research Information Officer – Johns Hopkins Medicine

Sounds good to me.

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

Okay, well, so since Arien and Lisa will be charged with holding ONC accountable it's good with me too.

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

Thank you very much.

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

Oh, anytime. So, I wonder because Michelle, you know, we did have to get this approved, are there any other final comments, we have one friendly amendment that Floyd has just offered. Anything else folks would add?

Okay, well with that then are there any objections to forwarding this report to ONC with that additional Floyd recommendation in the form of a formal letter?

Great, well none being heard Michelle I think we have accepted those recommendations and we will forward them off to you.

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

Thanks, John.

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

Well thanks very much Chris and Floyd and of course I think your visionary recommendations are exactly right and so I hope we can all achieve them. So I think we're actually ahead of schedule now. We have the Precision Medicine Task Force update and so are Leslie and Jon ready for that?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

I'm certainly here, Leslie are you by chance of the phone?

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

I don't think Leslie's on today.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yes, I sent her an e-mail asking if she was going to be...if she was on the phone but she's not so I am happy to take the reins in the interim period, but let me get off of speaker and pick up the handset and that way you all can actually hear what I have to say. Does that sound all right?

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

Perfect.

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

It sounds much better.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Lovely, thank you. Okay. Well, so we're going to come back, you know, as one of my favorite movies from the 80's says, is, you know, the dog returns to its breakfast, we would like to come back and revisit precision medicine.

I want to start I think by thanking profusely both the Precision Medicine Task Force members who labored with us furiously over the summer and the staff that were involved with that and all the folks that came to testify to us as well as my colleagues here on the committee for working with us on that. It was really a tremendous effort to pull it all together.

And I told you upfront about the importance for doing it and what I will highlight to you is that we started the Task Force in July. We got recommendations back in September. You all approved them and they were forwarded. And for those of you who are interested in this particular initiative probably know that the National Institutes of Health issued just recently several funding opportunities for the upcoming initiative into which if you read carefully you will notice your recommendations were incorporated as requirements.

So, for the use of standards and certified technology applicants have to talk about how they're going to be using those and will use them in evaluating the applications that come in. So, had it not been for your timely and effective action we likely would not have gotten those sort of recommendations in. So thank you for supporting the president and the administration in moving that initiative ahead.

There was good work that was done over the summer but I think that when we made our presentation in September you all recognize that there was still fertile ground to be addressed here in addition to NIH's funding we are awaiting our 2016 appropriation but we are planning in our budget request at ONC an additional \$5 million of work to advance standards and privacy policies that support the Precision Medicine Initiative. So, in that vein we would like to continue to ask for your advice. So, if you'd advance to the next slide please?

To refresh your memory, for those of you that do not, you know, completely live, breathe, eat, sleep, etcetera precision medicine, a year ago in the State of the Union the President announced the initiative followed up by a White House event.

Over the past year there have been a number of well-conducted, high profile, publicly available workshops held by the NIH and our colleagues on the Precision Medicine Initiative which culminated in our parallel FACA universe, the Advisory Committee to the Director from NIH, received a report and accepted all the recommendations and again for those of you who like to compare documents you'll notice that those recommendations map very close with the NIH funding opportunities.

The statement, admission statement of the Precision Medicine Initiative is here, I am not going to read it to you. I encourage you to read it, you know, I'll just highlight really the part about empowering patients and participants, and researchers, and providers working together. Next slide, please.

Our role at ONC in the Precision Medicine Initiative is of course to, as Chris mentioned, not Czar over but coordinate with our federal colleagues and again, for me that's been one of the real joys of working with our colleagues at the White House, at NIH, at the FDA, Veterans Affairs, Veterans Administration, Department of Defense and many folks in the private sector.

Our role is to recommend policies and standards to support privacy and security participant data, to identify standards that support a participant driven approach to data contribution and to coordinate with others to identify opportunities for innovative collaboration around pilots and testing of standards that support health IT interoperability for research. Next slide.

Just to revisit your final recommendations. Next slide. As I mentioned the presentation and acceptance was on September 22nd. We did a summary on October 6th to the joint committee. The categories of standards and recommendations were readably applicable in green, those are the ones that are included in NIH funding opportunities.

I will also point out that the promising standards for precision medicine, the ones in yellow, are also included in the funding opportunities for applicants to describe how they might pilot and use those promising standards not requiring them for use of course but saying, you know, these are promising, you know, can you talk about how you're going to be using them in your applications or you might be using them in your applications.

Gaps, we all know that there are gaps and those are in the red slide and then accelerators are in blue and then the recommended actions to advance each standard and emerging standard recommendation. Next slide.

These are the green and, again I'm not going to read these recommendations back to you but just, you know, the actions to advance those were to follow the existing standards processes that were there for interoperability standards advisory and other regulations.

For family health history and for HL7's DIGITize Action Collaborate draft LOINC specification the actions there were to apply accelerators through various things. We're hoping that having people think about those and talk about them in their applications for NIH funding will help accelerate thought and actions, spur actions around those. We're looking at other means as well. Next slide.

The yellow, promising standards all listed out here for one of these the authorization standards recommendation was to follow existing standards processes, but for the others that were listed up here the recommendation was to apply accelerators. Next slide.

The gaps, looking at the community of stakeholder group to address granular dynamic computable consent, addressing race and ethnicity, working with stakeholders to define a minimum data set and those all were actually recommendations to form Task Forces to advanced precision medicine.

I will call out, just since I'm kind of doing a little cross walk verbally here between NIH funding opportunities and your recommendations, the funding opportunity for the coordinating center for the Precision Medicine Initiative is envisioned to capture a centralized database of a subset of a data for the Precision Medicine Initiative and there is some discussion in that funding opportunity about that. Interesting things like your microbiome and your exposome, and your phenome, you've probably heard me using that word before.

And then finally, capture sexual orientation and gender identity which will remain challenging. At the time that these recommendations were made in September we had not of course finalized our 2015 edition certification rule. There are requirements about sexual orientation and gender identity in that rule. Next slide.

The blue slide, like the blue room, so these were accelerators so things that were thrown out here included use cases or pilots, support incorporation of healthcare provider organizations in the UMLS Methathesaurus and connections, no I'm sorry that not about healthcare provider organizations, no, of HPO in the UMLS Methathesaurus and connections between HPO and SNOMED CT looking at supporting ongoing OMIM work, Online Mendelian Inheritance in Man, codes for phenotypes, genotypes and links between the two and finally support for dpSNP and ClinVar. So, those were interesting opportunities that were presented to us that we're kind of thinking about as well here and then onto the next slide.

So now that NIH's funding opportunities are out I think what we would like to ask, as we alluded to the beginning, we'd like to ask the Task Force to come back together. We would like them to wrestle with the following things, first how can ONC support the use of emerging standards such as FHIR, OAuth 2 to support individual data donation to precision medicine in addition to inclusion of participants through large healthcare provider organizations, fortunately there is one funding opportunity, the NIH's recommendation was very clearly that folks should be allowed to directly participate and there are funding opportunities out related to that. So, I think that we're interested in hearing more about that.

The second one is what is the best way to execute on the Task Force's recommendation that ONC convene stakeholders to address dynamic computable consent? We think it's a good idea, we want to hear your further thoughts on that.

Third, what existing work can ONC support to improve race and ethnicity standards and capture of sexual orientation and gender identity data so that they're adequate for precision medicine and directing therapy or clinical decisions.

And then finally how should ONC execute on the recommendation to define the minimum data set and/or means required to make precision medicine data useful in a clinical setting?

You know what I will say is that what is...there is a lot of discussion and a lot of thought about precision medicine, ultimately what all of us seek through this initiative are better outcomes for people, right? That's what we want. We want people to live longer, suffer less and get better value for what we pay. And we think that an individualized approach to people's data, genetic information and lots of other types of information about them is going to get us closer there but, you know, we do want to be able to loop it back to the, you know, setting of care and the setting of people's lives.

So, would love to bring those folks back. Leslie has graciously agreed to continue on with the work. In the same vein, as my announcement at the top that I was going to step back from co-chairing and be an ex-officio moving ahead, I'm going to step back from co-chairing this Task Force as well. I am of course going to remain engaged and participate but as your, you know, friendly neighborhood public servant as opposed to a co-chair, you know, it was important I think for me to be able to do that as we were kind of, you know, driving hard at a particular date but now that we've got a little bit of breathing space...so, I'm very pleased to be able to tell you that Andy Wiesenthal, another one of your veteran rock stars here on the committee, has graciously agreed to be Leslie Kelly's co-chair for this Task Force as we move ahead, assuming that the other Task Force members are willing to continue to work would love to them to or if for some reason folks feel like they have other obligations or are just bored out of their skulls and don't want to do it they are welcome to step back and we can, you know, revisit, you know, who else is on the Task Force. So, thank you very much for the attention. Esteemed co-chair John, I turn it back to you to conduct discussion.

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

Well, great and certainly look forward to any comments on that precision medicine work. One quick clarification Jon and that is the Fenway Community Health Center is one the Beth Israel Deaconess Affiliated Institutions and their academic group has made recommendations that things like gender identity and sexual orientation are very hard to categorize. That is to say, you know, a single SNOMED code that is applicable to all situations and all time periods and so what they have developed and validated clinically is a set of questions and answers.

I think it was Chris maybe who told me in the past if LOINC is the question SNOMED is the answer. That is you could have this sort of attribute value pairs of questions and answers that would then tell a clinician a number of things about the patient's preferences enough to respect their care needs and deliver decisions support and all the rest but it's a little bit more complex than just saying here's one SNOMED code for gender identity. So, I think as you put in the slide, that's where, you know, we yes have the certification recommendation but might we want to even look beyond that to a different kind of construct.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yes. First I can completely see Chris sitting in a cave in a robe saying that and yes that totally made me laugh. Thank you for that. Second, yeah, that is the kind of thing that I would love to hear more about so I appreciate that feedback.

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

So, other comments from the group?

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

John, this is Dixie, I have a number of specific comments. I don't know if I...

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

Please go ahead we have time and I figured when you saw a number of the things like consent, etcetera you would comment.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

You might have something to say, yes.

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

Yes I have something to say about the genomic stuff too. On slide five where it says support the DIGITize Action Collaborative LOINC specification and then it goes on to say suggest making more general and ongoing...DIGITize has already moved on to the next specification and I suggest that you make that a more general statement to support the DIGITize effort.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Okay that's a good one.

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

Okay, slide number six I had a couple of comments. It says something about OpenID Connect, OAuth and UMA should be considered for authentication and authorization. OpenID Connect and UMA are both profiles of OAuth 2 so that should be restated as, you know, to support OAuth 2.0 and its profiles such as OpenID Connect and UMA, etcetera.

And then on that same slide it says, in the next one, include more complete authorization standards such as IHE, XUA, I had a question about what is meant by more complete?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Dixie, it's Jon, I honestly can't answer that but I will get back to you with an answer on it.

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

Okay, thank you, because I think both of them are complete. I also think relating to...let me see, later there is something, a statement about less mature standards such as OAuth, at anyway rate, on slide seven I had two comments on that one too and then I'll shut up. There's a statement that says there are existing standards in this space but without clear implementation, guidance and alignment between HIPAA and Common Rule should be addressed and I have no idea what that means. So I doubt many people do actually.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Well that's probably...I mean, we can spend some time discussing it. It may be worth a longer chat. I think what I'm recalling is that we were able to identify standards for consent, right, and, you know, that fit in the granular dynamic computable way but that there was not necessarily consensus about how you implement those standards, how you actually get consent from folks and use those standards in such a way that it's reliable, comparable, computable.

I think that as we dug into it further, I mean, just what it says there, that there was some...especially with the Common Rule currently being in revision being a proposed format, I think that looking to ensure that the use of the standards and implementation are standards that everyone was copacetic with HIPPA requirements and that depending on how the Common Rule eventually finalizes that of course that would affect consent and does that help Dixie?

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

Well, I know what each part of that sentence means.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, okay, yeah, I used slightly longer words, but, yeah.

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

You know the whole thing doesn't...I don't know what the main point is being made.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

I guess the point is that there are standards but folks...there's not consensus on implementation specification for those standards.

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

Yeah, I agree.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

All right.

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

I think alignment of HIPPA and Common Rule, you know, that is a huge issue that deserves its own bullet at the very least.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Okay, yeah, that's fair, that's fair.

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

And then on slide seven, there is a recommendation that simply says microbiome, exposomes, etcetera data standards but it's not really a recommendation. And as a general comment genomic standards there are a number of comments about...recommendations having to do with genomic standards and genomic standards are evolving globally with NIH obviously taking the lead here but EBI is equally, you know, equally respected in the genomic space of...standard space.

So, I think that the recommendation rather than getting behind specific, you know, nomenclatures that exist today and methods that exist today but would be to just follow and facilitate collaborative efforts toward achieving international standards on genomic...for genomic data.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Okay that's fair. I think the point of this cell in the table, right, is that we thought there was a gap, right?

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

There is, there's a huge gap, yes.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, yeah, yeah. So, I think this just identifies, you know, beyond, you know, the usual suspects as, you know, they would have said in the movie, that there is, you know, hot topics, right, are things like your microbiome and your exposome things like that and folks are going to want to collect data about that, bring it together, analyze it, aggregate it, right, but, you know, in the absence of good standards and implementation specs you run into methodologic issues when you get to the aggregate and analyze part. So, I think that's mainly what that is meant to call out and your point about the follow the emerging consensus with all the different players that you mentioned is a great one too.

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

Yeah, there are standards in many...the whole area of genomic data cries out for standards on a number of aspects and there's a lot of...not disagreement but there's a lot of different standards out there just like, you know, health data was 10 years ago and I think that ONC has a role there but it's more of a collaborative, you know, the "c" in ONC...

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yes.

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

A collaborative effort in bringing people together and helping support reaching consensus on these standards is the right role rather than recommending specific, you know, ClinVar versus ensemble or something.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Okay, okay, great point.

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

Well, thank you...

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

This is Michelle. I just want to note Dixie, not to put you on the spot but I know that as we talked about moving onto the second part of the charts that I know people would love to have you be a part of the group so you'll probably be hearing from us on that matter and hopefully we can get your comments earlier on in the process. And also we have Arien Malec in the queue.

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

Yes, Arien, please go ahead?

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

Thank you. So, I'm going to dig in a couple of areas. This is great. I want to double down on Dixie's comments relative to the Common Rule and HIPPA and talk a little bit about this notion of computable consent because I think these issues are linked.

With respect to the Common Rule in HIPPA you start to pose these sort of Zen-like...of if I donate my data for a variety of purposes under HIPPA and clearly under HIPPA as patient with appropriate authorization I can donate my data to project on the side of a building but if it's used for research does it then fall on the Common Rule, under the Common Rule and therefore I need to follow informed consent and a whole different set of processes.

So, I completely agree with Dixie that clear harmonization for PMI of HIPPA and the Common Rule with respect to data donation both with respect to data donation from individuals and data donation from organizations for research purposes. You also get these other issues of under HIPPA I can take data and use it for operations purposes for quality improvement to discover that it's better to treat, for example, cardiac patients with this genotype this way. But if I then publish that data it falls into the Common Rule and so the same research that I do is now not permissible without additional consent.

And again, to the extent that we can convene work to...if there is rulemaking under way great there's rulemaking underway, but to the extent that we can better harmonize and provide better guidance for when HIPAA is applicable when the Common Rule is applicable and better notation around the differences between the two that would be highly useful.

The second comment that I have relates to the notion of computable consent and I've had somewhat of a see-change in thinking about this topic. When you frame the topic as computable consent you're focused on all the ways that a patient can say "yes" and what legal agreement they're saying yes to. I believe that if you flip the problem around and frame up the notion of purpose for use for a data request and then some additional parameters around that data request you can often get to a more substantive answer.

So, you know, the patient is saying "yes" or the organization is saying "yes" to some data request for some use and that use may be authorized under HIPPA. It may be authorized under explicit patient consent that has been provided for that purpose.

So, in the case of PMI I would highly encourage better granularity in terms of purpose for use and I believe that if we focus in that area we'll get somewhat better outcomes relative to understanding what we're actually computing consent for.

So, to give the examples that I just gave, if there is a data donation purpose for use then, clearly, there is a pretty clear path for the patient to say "yes, I donate my data for these purposes." And again, I think you need to get a little more precise about what purposes the patient is permitting use for.

And the last topic is that I strongly believe and I've had conversations to this effect that some of the work in the Argonaut Project with regard to what we've discussed as the EMR to EMR use case is actually quite applicable to the data donation use case except with respect to this notion of purpose for use. That is we've already got good work underway for the OAuth 2 mechanics for how one system can request data from another system and a lot of the things that change really are those parameters for purpose of use that answers the question of what am I authoring requests for.

What we haven't made progress as an industry yet is the batch side of this by which I can request data from an EHR for a population of patients, again for a specific patient, Query Health did some work in this area, but we haven't been able to move the ball forward.

And so I might suggest that we do some...that ONC do some convening relative to population level queries and I know that DAF is already thinking about this but to the extent that we could have the...you know for some purpose parameterized by some purpose of use and, you know, some authorization framework the ability to request a population of data in for example a set of FHIR resources and then get that data for that use we'd be opening up data for PMI but also for population health and quality measurement and data transition and that kind of thing. So, we'd be opening up a spigot that could be used for multiple purposes. I think that's the sum total of my comments. But this has been great work and this is really the future of a learning health system so it's important to get this right.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Those are superb comments. All the comments are superb and I'm...that's one of the reasons why I love working with you people. You know I will simply add that, you know, we are talking about this in the precision...this is kind of broken off of your last point, that, you know, we're talking about this in the context of precision medicine, you know, I can tell you that my other federal colleagues at the FDA and at CMS and other places have been eyeing this initiative with great interest and excitement because it brings it home. The value of the data that they've gotten and moving it back and forth and, you know, we've been having, you know, for a while we've been having these conversations but suddenly it feels a lot more real to them and to us about, well we could be doing that or this or that, or, you know, that regulatory process, or, you know, that, you know, payment process.

So, agree totally with what you're saying. I think that, you know, you've got to...just like with interoperability, right, I love talking about interoperability, but then I often say "for what." So, you know, the fit for purpose is I think not just a name I think it's important and I think talking about it is good. So, thank you.

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

This is Dixie, could I add something to Arien's?

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

Please, do and I think then Jamie Ferguson is in the queue. So, go ahead Dixie.

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

Yes, thank you. I totally agree with him that when you talk about computable consent it's really important that you really address the specific purpose for which the consent is being given. But I'd like to add to that. There are a lot of people that think computable consent is taking the signed form and digitizing it and making it exchangeable with the EHR but it's also important that consent be made dynamic so that people can change their mind across time and in individual circumstances. So I would like to add dynamic to his comments if he doesn't mind.

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

That's absolutely right and thank you for that.

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

Very good, well, thanks. Jamie?

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

So, I think there's a theme here, thank you. And so I also wanted to talk about the purpose of use and maybe take it a step further in looking at the different scenarios that are within PMI. So, one scenario that's within the initiative has to do with submission of data to third parties. You can think of it as similar to the way we would submit data to registries or public health and so considering the recommendations for standards on pages 5, 6, 7 and 8 I would generally agree with, it's subject to the other caveats that have been mentioned. I agree with those recommendations for that scenario for the submission of data.

But I think that at the same time PMI includes other use case scenarios such as dynamic access or direct access to the patient data in the provider EMRs and so I do not agree with recommending use standards for that new use case, repurpose of use because it's a totally different use case. It's untested. It really needs development and piloting analysis before moving forward for the dynamic access scenarios as well as the query scenarios.

So, submitting data to a registry or a database, or third-party like that, you know, I think is one thing and we have developed standards for those purposes. But I think PMI is also at the same time proposing something totally different that really needs to be considered differently and separately.

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

Jon, any comment on that?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

No just well stated. I think that this is part of the dialogue that we value, right, from the committee. So thank you Jamie, appreciate you bringing that in and I will look forward to talking that out more as we kind of get deeper into it.

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

Well, Michelle, are there any other comments in the queue?

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

No more comments in the queue.

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

So Jon we did not have a specific recommendation or a vote on this one. I think your charge is that you will, with Andy Wiesenthal taking your position, now reconvene the group and have them expand their scope and make some additional refined recommendations taking into account some of the comments that have been made today.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Yeah this is...exactly, this is the chance for folks on the committee to say “you idiot don’t do that.” And it doesn’t sound like anybody is saying that.

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

Well, very good. I think Michelle we are at the end of our agenda. Of course we have public comment but anything administrative or any other things that you have for us?

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

Not from my perspective. I’m looking forward to seeing you all in January at the January 20th Joint meeting.

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

Right and I should make the comment, Michelle, that for any of you who saw the New York Times piece over the weekend where Katie Hafner and I reviewed what we actually do while we’re on conference calls and the photospread of my doing calls with an alpaca, geese, in a treehouse, etcetera this is a type one conference call it has my full attention don’t worry. So, Michelle, go ahead and let us open to public comment unless Jon did you want to take some time before public comment to review anything from our prior year?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

I have a forty page speech prepared by let’s have public comment first.

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

Okay, very good.

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

Operator can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Michelle, actually, while we're waiting for folks to queue up for any public comment do you want me to just go on ahead and say what I want to say?

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

Yes that would be perfect.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Okay, perfect. So, again thank you so much for the wonderful meeting today, you know, again, one of the reasons why I love working with you people is that it is always, you know, bright, cogent comments. So, it turns out, through some accident of fate, December 10th is exactly one year to the day from when I first co-chaired my first Standards Committee meeting. So, it has been quite a year and I want to thank you all.

So, you know, there's four kind of broad categories of what I've been thinking about. You know as I look back over the past, you know, year, right, and I think, okay, so what happened over this past year? Well, you know, the Federal Health IT Strategic Plan and then the interoperability roadmap, and then we had proposed rules for the incentive program and 2015 edition certification, and then MACRA passed and the Secretary has been forging ahead with delivery system reform, and the house and senate have been working on 21st Century cures and innovation. And we've had a few HELP hearings with the Senate HELP Committee along the way. Oh yeah, ICD-10 rolled out. And, oh, yeah, final rules got put into place and oh, yeah, precision medicine, and, oh, yeah, Interoperability Standards Advisory and then I'm like, oh, oh that's where my year went. It was a busy year we did a lot of stuff.

And, you know, I lay that list out for you because, you know, those are big things in my world and I think they're probably big things in your world and, you know, in every one of those I think you can probably point back and see just, you know, the critical part that standards and standardized data play in making all of that work. So, at, you know, one point in my life, you know, when I thought about standards and committee work, you know, my eyes glazed over and now I'm like "nope, nope that's pretty darn important."

So, that's kind of, you know, as I think across the year what's happened. You know when I look back at the specific work of this committee, right, digging into the S&I Framework, digging into the interoperability roadmap, digging into the rules, digging into the Interoperability Standards Advisory giving us great feedback on that, you know, all the different, you know, Task Forces and Workgroups and, you know, framework review sections it really has been, you know, tremendous, tremendous yeoman's work, you know, meaty, substantial, significant, impactful, you know, the list of adjectives just rolls off my tongue.

So, I'm just so grateful to have been involved with the work of the committee and the people on the committee. It really has been, you know, a highlight of my professional career and I am grateful for it. Thank you.

You know in terms of people, every year there is always a transition that is happening in everybody's lives, but this has been a big one, you know, for this committee. We have been said...I'm not going to roll off the list of names for you because I don't want to cry on the phone. We bided you to several legends in our field and have been grateful for their service and, you know, sad to see them go but we've also said hello to a lot of really awesome new folks and it makes me excited about the future of continuing to work with this committee and see it kind of move ahead.

You know I will name one name in the goodbyes, Jodi Daniel, you know, amazing public servant, you know, dedicated the last decade of her life to ONC, is onto amazing new horizons and new adventures but this was a significant goodbye in the past year.

And then I think just in closing I want to specifically highlight, you know, my partners in standards here, you know, Steve Posnack, Elise Anthony, Michelle Consolazio I work with some of the best people in the world. I really do and that's part of the joy of my job.

You know the final thing that I will say is I will reserve full, full comment for our next meeting but it is...I say this as a University of Virginia graduate where we talk about Honor with a capital "h" it has been an Honor to work with John Halamka just a truly extraordinary individual and has been part of the experience of a lifetime. So, all the errors have been mine and all the successes are yours and thank you so much for a tremendously fulfilling year.

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

Well, thanks very much. I'm honored by your comments. Before I make my closing comments, Michelle, do we have any folks who want to make public comments?

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

No public comment.

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

Well Jon as you said, if you look back in the last year and we had many Meaningful Use Stage 2 simplifications and Stage 3 final rule with comment period. We had ICD-10 come and go. We had HIPPA enforcements and more security threats than ever. And we had the Affordable Care Act rolling out and all the new IT systems to support that.

And of course, sometimes, you know, you look at the press on any given day and it says “oh, the world is imperfect.” “Oh, we aren’t done.” “Oh, there was something that didn’t go as well as it should.” But, I, as you suggest, look at the last number of years we’ve all worked together and look at the trajectory over that period of time and so Floyd and Chris, you know, I was looking back at the charge to your Task Force in 2011 when it was debating how we were going to get through ICD-9 and 10 and I what was the role of CPT and now we’re talking about total unification of vocabularies in SNOMED. I mean, we wouldn’t four years ago have even proposed that, well maybe Chris would have, but, you know, now it seems very, very rational.

And so, I think you said, Jon, you know, look at the last year and the trajectory has really been excellent and I look forward to the trajectory ahead which Arien and Lisa I think now that in effect ONC is ex-officio they will be driving the agenda. So, a Federal Advisory Committee is just that, you know, and in some ways, Jon, I think the Federal Advisory Committee becomes almost like your Board of Directors it makes management advice and you are ex-officio there to listen. And, yes Arien and Lisa that gives you a bold new responsibility but it also gives you the freedom to drive the agenda. So it should be a great next year. So with that any closing benediction Jon?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Let’s be careful out there.

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

Well, very good, well thanks certainly to everybody today and I look forward to seeing you in person in January and have a wonderful holiday season.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health

Thank you.

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

Well, talk soon.

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

Thank you.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you.

Meeting Attendance							
Name	12/10/15	11/03/15	09/22/15	08/26/15	06/24/15	05/20/15	04/22/15
Andrew Wiesenthal	X	X	X	X		X	X
Angela Kennedy	X	X	X				
Anne Castro		X			X	X	
Anne LeMaistre	X	X	X	X	X	X	X
Arien Malec	X	X		X	X	X	X
Charles H. Romine	X	X				X	X
Christopher Ross	X				X	X	X
Dixie B. Baker	X	X	X	X	X	X	X
Elizabeth Johnson			X		X		X
Eric Rose	X	X	X	X		X	X
Floyd Eisenberg	X	X	X	X	X	X	
James Ferguson	X		X	X		X	X
Jitin Asnaani	X		X				
John Halamka	X	X	X	X	X	X	X
John F. Derr	X	X	X		X		X
Jon White	X	X	X	X	X	X	X
Josh Mandel		X	X				
Keith J. Figlioli				X	X	X	
Kim Nolen	X	X	X	X	X	X	X
Leslie Kelly Hall		X	X	X	X	X	X
Lisa Gallagher	X		X	X	X	X	X
Lorraine Doo	X	X	X		X		X
Nancy J. Orvis	X	X	X		X		X
Patricia P. Sengstack	X	X	X				
Rebecca D. Kush			X	X		X	
Richard Elmore	X	X	X				
Steve Brown			X		X		X
Wes Rishel	X	X	X		X	X	X