



HIT Standards Committee Implementation, Certification and Testing Workgroup Final Transcript June 17, 2015

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Implementation, Certification and Testing Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Here.

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

Hi, Cris. Liz Johnson? Andrey Ostrovsky?

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

Here.

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

Hi, Andrey. Danny Rosenthal? David Kates? John Travis? Kevin Brady? Kyle Meadors? Rick Moore? Sarah Corley? Steve Waldren?

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Here.

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

Hi, Steve. Udayan Mandavia?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare

Here.

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

Hi, Udayan. And Zabrina Gonzaga?

Zabrina Gonzaga, MSN, RN, cPNP – Senior Nurse Informaticist – Lantana Consulting Group

Here.

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

Hi, Zabrina. And from ONC, do we have Scott Purnell-Saunders?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Speaking; here.

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

Hi, Scott. And Mazen Yacoub?

Mazen Yacoub, MBA – Healthcare Management Consultant

Here.

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

Anyone else on the line from ONC? Okay, I apologize to those on the public...we've had some quick changes at the last minute here so hopefully we get a few more folks as we go through the discussion, but bear with us and I'll turn it to you Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, thank you Michelle. So today we've got two agenda topics; one is pretty brief, Scott Purnell-Saunders is going to walk us through the report out to the Health IT Standards Committee on June 24, our meeting next week, which in some ways is an advancement and recapitulation of the comments that we offered previously. And the majority of our time is going to be discussion of the 2015 Edition draft test procedure comments, and we are all hoping that we'll have some additional members of the workgroup by the time we get to that in 10 minutes or so.

So, unless anyone from the workgroup has any further comments, I think we should turn it over to Scott to walk through the report out materials for June 24.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great, thanks Cris. This is Scott Purnell-Saunders from ONC. We'll be reviewing 3 slides from the previously distributed deck on which we'll really look at the recommendations for prioritization and standards against and for adoption for the Implementation, Certification and Testing Workgroup to be pushed forward to the Health IT Standards Committee next week, during the meeting on June 24.

So the slides you see here really goes into the standards that we're recommending for adoption received from feedback throughout the discussions with the workgroup. The gap certification

eligibility table to minimize the variability across ACDs and ACLs, the common clinical data set definition was generally supportive with the inclu...but the inclusion of the unique identifier...unique device identifier seemed to be problematic just at this point because that was relatively premature at this time.

The ONC certification health IT module should be clearly articulated but field surveillance of the deployed system would entail. And there was a lot of discussion around on what that looked like, whether that was going to be something that would actually be used in a clinical setting or something that could be facilitated in the setting that wasn't quite clinical but was less laboratory. The final one was the generally supportive of the following list: the Open Data Certified Health IT product list or Open Data CHPL, retesting and certification as a whole and refining that to be a lot more clear and transparent than before, design and performance and then removal of the MU measurement certification requirements to better isolate the Health IT Certification Program as a whole.

And I'll pause there for any additional questions or feedback. Any areas that we missed or can be a little bit more clear?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Scott, I think this is a nice distillation of our comments previously. I appreciate the editing work that's gone into this.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Thanks Cris. So, anybody else have feedback?

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

No, this is Steve; I agree, looks good.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great. And go to the next slide and these are the lists of private parties that were recommending against adoption at this time or against adopting at this time. As was said on the last call or last slide, excuse me, the unique device identifier is problematic for a number of reasons, particularly for ambulatory practices amongst the others that were listed.

The immunizations mapped to NDC codes, the C-CDA creation performance in general was identified as a good concept, but definitely more clarity and constraint's going to be needed as we move forward with this. And then the base EHR definition while it was a very large topic as a whole, consolidating redundant certification criteria (b)(6) and (g)(7) and including the security criteria 315 (d)(1)-(8) for the consumer access being optional.

More clarification and clarity around the safety enhanced design, indicating that will require recruitment of clinical end users for testing and reduce testing burden. That goes back to the other slide where we discussed end user testing and in the field testing and what that would look like; safety enhanced design is a topic of a lot of conversation within the group and surrounding this to try to, you know, improve it as a whole, but trying to make sure that we're not being burdensome on the industry with things that can be done without as opposed to things that would be nice in the end proposal. And then finally WCGA or Web Content Accessibility Guidelines proposing to raising that to level 2 Level AA due to lack of quality compliance and

testing tools. And we're working on testing tools as well surrounding that, but because that's a new standard, that seemed to be problematic.

So I'll pause here. We do have one more slide that will go against, well not against but will follow along with additional recommendations against adoption. We can talk about these currently.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Scott, this is Cris. I think I'm interested in making sure we have clarity of language. So the third bullet point about Consolidated CDA creation performance; I wonder if we can be a little clearer about that because someone might wonder, are we against the C-CDA? What is it that we are against specifically and can you help articulate that a little bit more clearly?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

I think the...from what I took from it, they're various...C-CDA as a whole makes sense and it looks good to kind of propose, but because we want really, well at least the draft NPRM at that point wasn't really specific about all the areas to which C-CDA would be constrained. That opened Pandora's box a little bit; we received a lot of, I mean, current comments and feedback on areas where that should be better reduced and it's not necessarily a...not support of the C-CDA as a whole but really where we can further specify where those requirements are between us and also between CMS. Because there have been some issues in the past where we propose something that CMS did not and that created some inconsistencies as a whole with how it was going to be adopted and implemented across the industry.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'd love to get a little bit of feedback from other workgroup members. I'm, Scott with all due respect, I think I hear what you're saying but I'm not sure this articulation gets that point across...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...and I think we need to tighten what point we want to make. Do others on the workgroup want to comment on this?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare

This is Udayan and again one more point related to this is the two...like managing two standards like 1.1 and 2.0.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And your point would be that we want to go to one of the two of those?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay and that we should move to 2.0?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare

Yeah, it is a minimum...standard because otherwise we will need to manage two different vocabularies according to each of the standards and it's just going to be really difficult for health IT vendors to manage those things.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Hi, this is Sarah, I'm sorry I joined late...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hi, Sarah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...got some dreadful food poisoning in my travels. I thought that 2.1 was the preferred one that it had more backwards compatibility than 2.0; is that not true?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I...Sarah, my recollection is that's where we landed as well, too. And I think our feedback was further constraint wa...that 2.1 was good and further constraint activities should continue. Is that, I'm...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yes, that's, I mean, Dave, John, that's what we had, I thought, said.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sarah, unfortunately you're flying solo by the way; Dave is...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

No, I'm on now Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

John's here, all right, we've got another...to the quorum.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, I think that's right. I'm trying to look back at my notes, if you'll indulge me, as to what we said.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

This is Scott; I'm trying to think back to, I thought for...I mean, 2.1 was definitely where we landed but I thought they included 1.1 was to not force people to upgrade if they didn't have to. But am I wrong in that? And that's why I thought we had both listed.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well I think our recommendations from May were that constraint of the C-CDA was very valuable and that we encouraged additional constraining. I think that was our overarching comment.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, that was and there are always time issues in things that are still draft standards because we have said that draft standards shouldn't be required until they are mature standards but that the direction is moving not to 2.0 but to 2.1 because 2.0 would be problematic in terms of backwards compatibility. Requiring 2 would be disastrous in terms of workflow; my interoperability folks say that if you required that then, you know, you wouldn't know what the person you were sending to...receiving and you might end up having to send two and it could be very, very problematic for workflow.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Can someone remind me, does the Meaningful Use Rule specify a version of C-CDA or does it say C-CDA generally? I'm sorry to ask such a basic question, but frankly I don't trust my recollection; is it specific around which version?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I don't think that it does because don't...well...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah, I'm looking at the CMS regulation now to see if it does; I don't think it requires...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

I don't think it does because the reality of it is, especially due to the transition year in 2017 that's proposed, both are going to be in play because you're going to have 2014 CEHRT out there as well as 2015 CEHRT potentially and Stage 2 and 3 use going on. So, and I want to say that transition of care now is by, well that...never mind, that doesn't go towards the content, that's the electronic...the secure transport that's by any electronic method. But I think it's because 2017's a transition year, they didn't mandate it for use for Stage...it mi...I don't think Stage 3 is specific to that; it would really just be based on what 2015 Edition can support, which allows for either.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Generally I think they don't tend to specify that on the provider end, it's on the vendor end...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

No.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...that they...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Right. Yeah, from what I'm...I just pulled up, they're not specifying any particular version from the CMS end.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well I'm really glad to know that my knowledge was not...didn't have a big pothole in it. So given all this, I mean I think our recommendation is that we want to urge additional cons...clarity and constraint work around Consolidated CDA; so I'm not sure what we want to put on the slide,

but I'm not sure that this, as written, belongs under a slide that says recommend against adoption.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah, I'll...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well, no, this is talking about testing 101, so isn't that what it is? This is creation performance is...was that idea that you would have to be able to consume and create and parse and reject appropriately from, you know, up to 100 different C-CDAs that you could be sent. So I think we don't want to adopt that at this time because we don't feel that it is sufficiently constrained yet.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Uh, correct. So, I think we want to be explicit with the sub-bullet then under creation performance. As it reads, I'm not sure...Sarah, your point is exactly right; I think we want to say we're in favor of C-CDA clarity and constraint, but not of the creation performance requirement. Is that accurate?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yes.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

The other thing that comes to mind that I think we said, and Sarah, you might recall this; as it's defined, I believe it requires conformance testing to all of the different templates that are implicated in the various criteria where C-CDA is used. So not only the transition of care but care plan, progress note, tran...referral note, etcetera and I...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Right and we had...we certainly had comments that we did not feel that all of those should be mandatory for their care settings...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...and we identified the ones that we thought, the minimum set that we thought were relevant for the ambulatory environment and the...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Exactly.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...environment.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Exactly, don't compel everybody to test all of them as a mandatory part of this performance criteria.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

And I'm...that was probably the other major thing I recall that we hadn't yet talked about.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So who can offer some specific language for Scott that we want to include as the third bullet point under Consolidated CDA? How should it be worded?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

I rather like what Sarah just said.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Which was basically, adopt a...adopt as a mandatory requirement only a...only those templates that are relevant to the domain, ambulatory or hospital and, I think, that are associated to the requirements of the Meaningful Use Program or what is the purpose of use at hand. I think we had a limiting factor in there, I may not be saying it very well, but it really goes towards what are the things that are required to sustain Stage 3 use; that should be the mandatory set; anything else should be optional.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So this is...that's good John, this appears under a title that says, recommend against adoption so we probably want to start with what we recommend against and then clarify with what we recommend.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Ah, yeah. I would say recommend against requiring all the template...the document templates to be mandatory, just one size...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

No, I mean, it depends on how cluttered you want your slide; you can list the ones that we feel should not or that we think should not be required at this point of all vendors, because it's not necessary for the core tasks at hand. You know, what we've seen throughout this and commented is that it appears that anything that somebody said wouldn't it be nice if an EHR could get put in.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

And I'm sure there are some situations where some of those document types would be relevant, but they are not relevant for the base vast majority and when you require everyone have the exact same Cadillac content, it increases the cost and the complexity of the product without benefit to the end user. So we need to really look at what the core, minimal functionality is and then let the market define which additional functionality that a vendor is going to choose to provide for their market segment, based on the needs of their market segment and not, wouldn't it be nice if?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So for this slide I'm hearing a proposal to say with respect to Consolidated CDA creation performance one bullet that says do not require all of the proposed document types, just in the interest of brevity and a second sub-bullet that says continue with work around conformance, sorry, constraint and clarity. Does that sufficiently capture our points?

Zabrina Gonzaga, MSN, RN, cPNP – Senior Nurse Informaticist – Lantana Consulting Group

This is...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well, we also don't think that we need to have that extensive 100 C-CDA testing, that performance testing.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Umm, perfect, that could be a...either the first or the second bullet.

Zabrina Gonzaga, MSN, RN, cPNP – Senior Nurse Informaticist – Lantana Consulting Group

So this is Zabrina. I...so are we going to say that we recommend is it actual document types that are relevant to the setting and market? Is that what we're trying to say?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Oh, we did recommend them, I don't think you need...

Zabrina Gonzaga, MSN, RN, cPNP – Senior Nurse Informaticist – Lantana Consulting Group

Okay.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...to put them in a bullet, but we could reference our longer comments on which ones we did think we're for and which ones we're not.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I think we would put that in some written document to follow but the punchline here, I think, relates to don't do the creation performance work around multiplicity of types that's not required outside the relevant clinical setting, but focus our work on constrain and clarity. Am I

summarizing it accurately? I'm just trying to put words...I'm trying to put simple bullets on the page so we can get across the major points, because we can then follow up with written comments that are more clear.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, I think that that's fine.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

Zabrina Gonzaga, MSN, RN, cNP – Senior Nurse Informaticist – Lantana Consulting Group

Yes, I agree with that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. Any other comments on Consolidated CDA? Any other comments on this slide? Hearing none, Scott, if you could take us to slide 8, please; thanks for letting us have some time for some feedback on that.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Not a problem and we captured that so we'll work on getting that out to everybody as quickly as we can to make sure it's captured properly before final review.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks, Scott.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Not a problem. So, continuing on slide 8, request for comment on summative testing; should not be required but rather listed as an option. On the encounter diagnosis ONC clarified that this is meant to be billing diagnosis and whether it's necessary to include all billing diagnoses for encounters or simply the primary one. Medication dosing and update to include...exclude non-metric units if they are expected to be removed from the EHRs as a whole.

Implantable device list; most devices are not inserted in an ambulatory environment so including that there might be a little bit problematic. And pharmacogenic data standards; those standards are not mature as of yet to be included. Data portability; renaming bulk export of CDAs. And then the automated numerator recording and automated numerator calculation should not be a requirement for numerator recording for any measure where doing so would require additional clinical documentation that's not necessary for specific patient care.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

So it's a little bit misleading to say, recommend against adoption; it's recommend against adoption as worded because, I know that, you know, I wrote those comments on the medication dosing and I have no problem with limiting the display of structured sig fields to metric units only, as long as they are pushing the standard to remove non-metric as an option. So, well I guess you would say we're not recommending at this time, that is true, that the standard should be updated first before you start EHR...asking EHRs to not support something that is in the existing standard that's referenced.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Hey, Scott; this is Liz. My apologies, I had a little crisis here; what slide are we on?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Slide 9, excuse me slide 8 of the slide deck that ends in v3 as a file name.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, I've got the sli...I assume I have the slides, its labeled Data Portability? Slide 8 or 9?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

This is Cris, we're slide 8 and we're looking at some wordsmithing related to the recommend against adoption at this time. And...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

There...

M

You're in the other set of slides.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Got it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I don't know where you joined, but I think Sarah's overall comment was recommend adoption...recommend against adoption as worded for several...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...things, which I think is the best feedback.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

And so that's under medication dosing, Cris?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup, that's the one we were on right now.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...maybe other...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right. Thank you. Sorry, guys.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No worry. So Scott, I think Sarah's point was cor...important and reflected the workgroup, so, do we have some wording we can add or modify on that bullet?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah, I think I can just...what she said down and make that a little bit clearer. So I'll get that back out to you all.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So at the end of the day we're saying we're not ready to do this, is that right?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

As worded we're not ready...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Right.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right, okay. Thank you, Sarah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

The other one would be the second from the bottom one around data portability. I think John may have had some comments about this. I think this is accurate that we were talking about...the renaming and both export of C-CDAs or something like that was something that we thought made some sense.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Right, we thought it was not, you know, the requirement is not data portability, it is a requirement for both export of C-CDAs and it would set appropriate expectations if you called that requirement bulk export of C-CDAs...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...and did not call it data portability, which implies something completely different.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

This is Kyle; I just joined late and I think I mentioned that in the comments and obviously I've seen it here with like I think what Sarah says, it's the expectation of it. I know it's...we had that name in 2014 and they're just reluctant change it into the 2015 but she's right, I mean, it is about bulk export, whether you want to call it that exactly or not. But data portability was im...I mean, vendors were thinking something different than what really think, oh it's the intended; so we might as well just reset expectations if we're going to keep as...at least as it's written now, it is this idea of really about data sharing ongoing, not just I'm moving to a new EHR. That's really just one use case, they really wanted a broader use case for that functionality or that criteria, so we might as well name it appropriately.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So given that some of the focus and controversy on these areas as between Congress and the departments of federal government, I think we do need to be clear that we're recommending against, I think we should say something like broad or generic data portability, but we do favor bulk export of C-CDA. Is that acceptable?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah and I've captured that.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah.

Zabrina Gonzaga, MSN, RN, cNP – Senior Nurse Informaticist – Lantana Consulting Group

Yes.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Can I ask a question about the one just above that, the pharmacogenetic...genomic standards? It says the standards are not mature. So I'm assuming that they...that the workgroup believes there are standards but they're not ready for prime time, is that a fair assessment?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well Liz, this is Cris; I'll speak up just from Mayo's practice. I think we would say that there...we're in early days in how to represent pharmacogenomic data...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...and there's been question about whether that data should be maintained in an EHR context as opposed to the report or action that may be required associated with that pharmacogenomic activity that might...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So yeah, I think the argument would be that we're recommending that we not adopt any pharmacogenomic data standards at this point because they're simply too immature.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah and I was just thinking back to sort of Dixie's, you know, hierarchy that we've been talking about for the last 6 years of, is it really, and I think you pointed out yet another operational issue related to it, Cris, so that's...I just wanted to be sure because when we say they're not mature that insinuates that they are available but not in broad use or something and...or they're...even the standard themselves is not ready and I was just trying to clarify.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

So I guess you could say, well they are standards like LOINC for lab results, but there are no or not anywhere close to enough LOINC codes to describe all of the...found in nature.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Another one of the points that we made was that this is going to be very specialized work; it has not yet proven to have a return on investment using decision support based on genomic data. I know I was on a Blue Cross Advisory Panel and we looked at a lot of these tests based on genes and generally they don't yet meet the standards that we expect for evidence that they improve outcomes. So, you know, I mean some standards are missing completely; some are present but not mature if that was the way you decided to go. But it's not the only reason we don't think that you should do that because this is likely an area where vendors are going to be using external decision support vendors who...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...specialize just in pharmacogenomics, who are updating them as the research comes in, what a particular mutation or groups of mutations mean, so it's just...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...not ready for prime time on a whole number of levels.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So when we, and I don't know where this goes from here Cris and work team but, I would say that we've got...the slide's entitled recommend against adoption at this time; I think it may be adoption/inclusion and...but there's a mix of things on this slide that may or may not fall under that title, just more housekeeping. For example, under summative testing we're say should not be required. So I'm not sure what recommend against adoption means, I mean...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well again it's recommend adoption as worded or...well, the summative testing was a question.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

So...and then the encounter diagnoses, we're not saying you shouldn't have an encounter diagnoses, the question is, are we talking about billing diagnoses, because we've now separated them which has created a whole host of workflow issues.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Now providers have to double code for problem list and billing diagnoses...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yup.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...but we expect that they need extreme clarity so that everyone is coding the same way as to whether we're talking about every billing diagnosis for a given encounter...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Sure.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...or a single one; and if it's a single one, how is that single one supposed to be decided?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right. Okay, so we may need to wordsmith the title because I think there's a mix of things in here, all very good points.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Liz, we sort of swirled around that a little bit maybe before you joined, I think...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...this is, I think, aimed at our report out to the Standards Committee next week.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And I think we'll have an opportunity to supplement this with something that's written and more nuanced.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay, got it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...your point and I had a similar reaction when I looked at it but I guess my feeling is it doesn't hurt for us to have a slide that actually recommend against adoption of a few things.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

No, I 100% agree with that. I just think that...so let me ask a question. Data portability, if I read this just cold without folks to help better explain, I would assume that what you meant was you recommend against adoption of data portability. I think instead what you're trying to do is have it named...we are trying to have it named appropriately; that was my question and I can do the same thing with several of these.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, I think you can certainly title them better so that they're more accurate and that might mean changing the grouping of the slides...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...to say, you know, adopt but change the wording in the title.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Absolutely.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, it's more...yeah, it is more wording change or it's more suggested change than it is outright opposition in most cases.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah. Okay. Sorry, I didn't mean to get you all...Cris, and I, again I apologize for being so late, but it is what it is, I'm just trying to catch up fast.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No, it's really good so I think we should take one last word before we go to the...so, I guess I like the bluntness of do not adopt because it's...but I think we should probably change that to be something like do not adopt or modify and adopt...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right, no, I'm with you 100%; I do not think we should go in with namby pamby, you know, this would be okay kind of if under these circumstances. If we think it's not ready, we should say, it's not ready. If we think it just needs to have a name change, we should say that; I think we're on the same page.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. Well I...let's wordsmith this before it goes to the committee next week and just from a schedule standpoint, we took a lot longer on this than I think we expected to so, Liz, I suggest unless you or other members of the committee, workgroup have feedback, we should go to the other agen...the next agenda item and the other deck.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Works for me.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hearing no other objections, Scott, do you want to take us to the other presentation?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Right; please pull up the other slide deck. Thanks. Next slide...list the current membership again for everybody to know. Next slide; this will go over the test procedure assignment and the review lead, based on the discussion during the last ICT a few weeks ago. The slides that will follow this are in order of criteria number as they've been listed in this chart. So, we'll basically toggle back and forth between the review leads as had been assigned. We did, as we announced on the call earlier, David Kates won't be available for the call, so we'll discuss his...the feedback that was submitted on his slides and then I'll take any additional feedback on that for the team.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

David is on the call.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Oh, I thought David wasn't; I thought John was on the call.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

John is but David is...

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

David is not on the call, John is.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yup.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Oh, okay. All right.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great. So, next slide. Sarah, you want to take this one away?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah. So I have the general comments that we've asked for for all of the certification documentation where there should be links to the standards that are cited as well as a description in the document of what those standards are. This...the wording of this clinical decision support is somewhat problematic and there were a number of ways that I specified that it was.

The wording suggested that something was being selected, which meant it would have been preconfigured and I recommended different language to show that there are many ways that one could activate or add clinical decision support.

They...the wording of it also suggested that it all needed to be active, which meant that the end user would have to do something, which would be extremely disruptive to workflow. There's a lot of mention that the decision support had to be therapeutic or diagnostic and there are many, many types of decision support out there that are not just therapeutic or diagnostic. I think I gave you like two pages on this one that...so; we have three bullet points, so it's really been pared down.

And then the requirement for tracking of the actions that the end user had, I asked for clarification that they were only talking about tracking active clinical decision support that is clinical decision support that required an interruption in the workflow so that the end user would have to make a decision to either go forward or cancel. Because a lot of passive decision support is there on the screen, but you don't know whether the person saw it or not and you would just be making implications as to what their action was based on inaccurate information. But if you made all decision support active it would be just dreadful.

I did also mention, there were requirements for the extensive bibliographic evidence for decision support you had in your product. If we put in bibliographic information for every single type of decision support that might be in there, I mean you could consider ONC has published, or CMS I forget who published it, a clarification of what is clinical decision support, which is pretty much anything. And we certainly don't want to have our EHRs cluttered up with decision support references for every possible thing that you might be including, including passive.

It should be limited to what the vendor chooses to certify on. And I would anticipate that would be a subset of things where there is clear evidence like preventive measures where we can site the US Preventative Services Task Force for some of the clear quality measures that have

evidence to support the interventions they're hoping the decision support will facilitate improved quality based on proven research.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great; thanks, Sarah. Yeah, I definitely saw a lot more, a lot more of the details that you listed and we'll make sure those are included in the...in what's submitted to the rest of the team for discussion.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So one thing that might help is Sarah just gave a lot of very profound examples and even if we had just some sub-bullets underneath, just a couple, it might help. Sometimes in our effort to simplify so it's not so overwhelming, we might lose the flavor of, for example, the active versus passive is a huge issue. And I thought we had reached the point where there was not an expectation that the action taken had to be documented; and so if we're testing for that, there's a concern. Again, I'm sure that Cris and I will not have the kind of time it takes to go through that, but it is a huge concern as were many other points that were made. So maybe we need to expand this just a little bit.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I will assure you that once I recover from what I hope will not last another day that I'm also going to be cutting and pasting these and putting them in as individual public comments to make sure that it does get seen. But I think that our FACA has more weight than just my individual comments.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah and Sarah, if you will share those with Cris and I, just in terms of background information, if that's possible, then we may be able to better represent in a public record format, public hearing and record sort of format some of these concerns I think.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well I sent it out, I...didn't everybody...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...get it?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

No, I got it.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Should we go to the next one?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yes.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yes please, next slide.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

I think this is mine, I think I caught Scott because I got it to him a little bit late that he had no choice but to put these in pretty detailed, because he actually covered these pretty well for what we had in our submission. So to highlight things, similar I think what Sarah said, general comment, the test procedure, it's hard to provide feedback completely about the test method because we don't have test data, particularly for some that is content heavy as transition of care, very important that we have the opportunity to validate the validity...the clinical validity and relevance of the test data. That was something was a significant issue with 2014 Edition testing. And then certainly for the test tools for conformance issues and potential errors in conformance testing and logic; so that's going to be important before this is baked that there's that opportunity.

Very similar to what we were saying about C-CDA performance in our public comment discussion we had earlier on the call, a lot of that applies here. The criteria is proposed and test procedure as proposed has a variety of the C-CDA templates in it, so the same policy, we think, should be adopted here that there is a distinction between what is mandatory to be validated for the purpose of the definition of CEHRT needed for Meaningful Use and other stuff.

So that's, I think, the big upshot of the second bullet is because this criteria is part of the centrality and I think base EHR as well as what's required for Stage 3, there's a lot of extraneous stuff in it that doesn't have anything to do with what is required for meeting the summary of care and coordination of care types of requirements in view, download and transmit for the sake of Stage 3 use. So we really think where we got a criteria that's as bad as this one is, we need to be defining the mandatory element of it that applies to the definition of CEHRT and what is going more to the definition of CHIT beyond scope of Meaningful Use. And those things should either be made optional or conditional or whatever's appropriate to draw that distinction.

The procedure as proposed doesn't include test data that would allow for validation of valid and invalid C-CDAs and creation of C-CDAs. And kind of blending into the last point, it seems duplicative to have the test stuff in here that is doing a lot of the things that may go with the C-CDA creation performance, especially when 170.315 (g)(6) is required if you're certifying to 170.315 (b)(1), so why not kick over to C-CDA performance anything that is a duplication or an overlap. So those really need to be consolidated and leveraged such that you have one testing tool and method to be used for the purposes of both, not to be applied in duplication.

There was one area in the comment that we drafted that is not reflected here and that is just generally and probably part of the validation or performance of error handling and having good error condition definition and how error conditions will be tested for. So, open that up for comment. I heard Udayan on and I know that Kevin's on. I'm trying to remember who else is all on, but I think all of my workgroup is on the call if they have other comments to make.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

And I'm not on the workgroup but I did provide some general comments that these criterion need to have the link to the test tool...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yup.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...in them and the test tool needs to be mature and ready prior to doing any testing. And also recommended that if there is a test tool that works, that you should not have to have a visual inspection, you should, you know, the test tool should be able to create reports that you could then do at your convenience. Particularly if this goes through as worded with requiring a lot of different templates and different testing, it becomes very expensive for vendors to test when they're paying hourly to the testing bodies and pretty darned boring for everyone when you're just verifying that a test tool works that you could attest and submit your test tool results and save a lot of time for everyone.

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

So I just...Kevin Brady; I just wanted to mention that when we do visual inspection it's because the tool cannot do it. Case sample would be like incorporate a C-CDA. We send a C-CDA from our test tool to your EHR, there's no way for us to test that you incorporated that data without a visual inspection.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Well I think we'll touch on something very related to that Kevin when we get to clinical reconciliation that actually is a little bit of ironic nature to it because one of the tests there is to generate an outbound C-CDA to verify that the information got incorporated. But we'll reserve that, maybe that's a...

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

Well that would be one way that they would try to automate the process. So like if I sent you a C-CDA, you incorporated it and then generated it and sent it back to me, then I could tell that you got the data the way you were supposed to, all through an automatic test, no visual inspection. That's one way you'd get around it.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

I will say, and this is Kyle; I mean obviously currently there are still some needs, even with our existing tools to do some visual inspection, even like sending to the...there are some things it still is not checking for, and I'm not saying that's necessarily problematic as much as that is the reality. I know we kind of would like to get it where there's no need for visual inspection, the tool can do everything; but currently that's not...it's just that it's not there right now. I think the biggest thing too, while we'd like the tool to do all those things...need to be clear in any test procedure of here are the things that need to be visually inspected. Like if we know the tool is not checking for this, you know, vocabulary standard, then we need to call that out and make sure that these are the things you're checking for visually; and so the tool does these things, you're also doing these other things.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

It's an important part of the test method description to understand that certainly and I think that's where the comment on the...that didn't get reflected in here in a way on error handling and how that would be validated goes towards. But to me probably the most important comment specifically on this test procedure is the one about refining the mandatory nature of how...of what templates are tested to fit the purpose of the definition of CEHRT distinct from the templates that really go beyond that definition, like care plan. And there may need to be a scaling in the test procedure that there is optionality that if the vendor's not certifying for the related criteria that would really command the need to test to that template, it's out of scope.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Got it; thanks for that. John, were any of the comments on (b)(1)?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Umm, on...could you repeat that Scott, because we just went through (b)(1) here.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

I was asking if there were any other comments other than what you just...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Oh, I'm sorry; no, I think that was it.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Okay. You've got the next one, the (b)(2) as well so next slide, please.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Okay, it's clinical reconciliation. So a few things on this one, and you know they may not be against the spirit of what...of how testing would occur, but general comment that the reconciliation process can be satisfied by whatever manner the EHR product presents a clinical summary for provider review. So, there's an aspect of it that starts with that incorporation activity and it just that's not an area of prescription; we're going to stage things differently how we do it as a presentation for workflow.

Skipping a little bit to the third bullet kind of the same spirit that the reconciliation process does not make any presumption about how that reconciliation occurs, whether in one function or many or in distinct functions because of the different data types that are involved; meds rec is different from problem list reconciliation different from medication allergy reconciliation. There's potential for innovation there or different workflows that are appropriate to the nature of the item and especially I think with meds rec because so many other activities could be occurring in meds rec than just introducing and reconciling the list. But also doing other things that are already present in an EHR's workflow to do things like renewals or discontinuing of meds and that may be occurring at the same time.

We also suggested that the confirmation of reconciled list is not necessarily “per item” but may be of the entire list at the time the provider completes the reconciliation activity. So not to get prescriptive about how more or less the final list gets confirmed or how a given item is brought in and whether that validation occurs at an item level or a list level. And there’s a valid date for the entire list to be affirmed with no change. So, there’s a provider discretion element that obviously may not be part of the test procedure but is, nonetheless, a valid outcome to reconciliation that nothing may have changed. So, we just kind of some philosophical statements.

Now I’m trying to remember, Scott, if there’s a second slide here, but we had a number of comments on specific test steps that may have been finer points of clarification. But I think to summarize those, there’s a test step that includes validation of the source of the data elements and some of those steps we wanted to make sure were not prescriptive as to perhaps terminology that the EHR may use to present information about source.

So for example, one of the data elements may have been how the activity date or the event date is brought into the EHR and we di...EHRs are going to have their own vernacular for how activity dates or event dates are referred to, even though the C-CDA standard may have its own terminology for those source dates. So whatever we might represent as the meaningful activity date in the EHR for whatever row of data we’re referring to, we didn’t want to get constrained by solely how the C-CDA might refer to them, as long as we can show how that’s represented. Kind of back to what I think either Kyle or Kevin were saying, for visual inspection, the vendor’s job is to make sure that the tester understands how the source data’s being made use of and represented in the EHR once it’s a medical record entry as a result of reconciliation.

I think we had a comment on duplicates; so if you’re going through reconciliation and you identify something that really is in essence the same item as what the external lists may bring in. That there is an opportunity to consolidate duplication into a single representation so that you’re not, and I think that’s just common sense for the process and that that may be subjected to whatever reconciliation the vendor system is capable of doing to make sure that duplicate entries aren’t the result of incorporation and reconciliation.

I’m just trying to see if there’s another key point and highlight to make. Those...then on the point of generating, you know, the test method calls for, and this was a comment on the criteria as well I think in our public comment there that this should...the testing should not be limited to the generation of an outbound C-CDA. There’s a variety of reasons why that might be true. It may be a bit absurd to say if the vendor doesn’t support C-CDA creation but it calls for dependency on that ability to be able to pass the test, that’s not an outright requirement of the certification criteria.

I think a visual inspection of how the EHR represents a medical record entry once it’s been appropriated and reconciled should be every bit as valid, and that’s actually what was done in 2014 testing, so that should be testing evidence that should continue to be able to be used. Because honestly, the more impactful thing is how does the vendor create a medical record entry out of something they bring in from an external list; if that doesn’t work, your system isn’t worth much. So, the ability to prove by the means of display that would normally be used to look at a medication item that is a codified or recorded medical record entry that would result from reconciliation ought to be valid for visual inspection. We shouldn’t have to...I realize C-CDA creation might be a neat way to do it and wouldn’t necessarily say take it out, but don’t say that’s the only means by which we can prove that the reconciliation was successful and complete.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, there should at least be something there that says, if EHR is not compliant with the (d)(1) functionality, which is where you create the C-CDA for example, then don't do...I mean, we obviously, like John mentioned, when there's not...if they don't...if this is just more of a...this isn't an exchange system of any...in terms of creation outbound or anything but just simply consuming it and then reconciling to the provider. To make the C-CDA creation an absolute requirement doesn't make sense. I mean, I think honestly, even from an ACB, I'll just be honest, ATL; that even if it was written this way, I think we would know that, I think we would just say, well guess what, they can't create a C-CDA so we'll find some other way to do it and we'll make a note of that. But it would be...it would help to go ahead and just reference that.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yup. Agreed.

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

Yeah, I would...Kyle, this is Kevin; I agree, I just think they put it in, like I said, to try to automate this process without a visual inspection; that's probably what they're trying to get around.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, so like...

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

It should be either or, yeah.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...it out. Yeah.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

And the majority will probably have that and it is a good way of doing it, I think it makes sense...

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

Yeah.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

And it is a good way of doing it, I think it makes sense.

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

Yeah.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Let's do all this, send it back to us, we'll check it; oh yeah, looks good; you definitely have reconciled it, it just...

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

Right.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

So Scott, that's kind of the summary of what I would offer up and so open it up if anybody's got other comments.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

This is...another thing on...I would, and this is a need I think even now, and I think it's going forward and I know it's not maybe quite in the area of test procedure exactly but it's more from ONC guidance is when we talked about that you want to display this last modification date, and it gives some options as far as where the problem was documented or edited and when the allergy was updated, etcetera, all these things.

Since we are tying this information to a C-CDA XML, it would help to actually put some guidance there, exactly where in the XML, from a uniform standpoint across systems, you know from interoperability, where they should be looking for this and...meaning, you know, you can, whether you want to put the XPath location or what it is. I mean, and I want to be careful in this, I'm not saying we just do this casually; we need some good guidance from people who are experts in this area, but if we kind of put that forward there, and a lot of times people, I think, aren't always sure where do I get this information from, is it just that they...I'm actually incorporating this C-CDA and which, I mean I don't think that is, I think you should look at...see when it was, the C-CDA at least was created or when these individual items were updated.

But, it would help, I think, to provide some of this. If we're trying to be precise in using these different C-CDAs and these structure...these different documents, then we should also be precise in kind of where should they find this stuff. You know, where can they process, you know, the XPath location to get this information and then...and then that actually makes it honestly easier because then you're getting...about trying to automate things or at least remove human involvement as much as what if, you know, you had a tool that you could kind of, if you will, pres...indicate here this medication is recorded at this time, etcetera. And then here's the C-CDA, you go ahead and consume it, process it, you know, and we know exactly what the expected result should be as opposed to just, here's a C-CDA and show me something, you know.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Thanks for that feedback. So we'll definitely capture that in more detail and make sure that comes forward.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, the other thing is, I think the recommendations are point on and I think we need to say recommend not suggest. I think this workgroup has done an enormous amount of work and I would prefer that the language be stronger. This is very, very clear direction that can be incorporated into the thought process as it goes back to those that are preparing the test procedures. Good work, everybody, so far.

M

Thank you.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

So I think that's it on this one, unless anybody's got anything else.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I can spend all day on this, John.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Me, too. Me, too, I'm trying to keep my mouth shut because I could really get going.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You're just saying everything perfectly.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'm applauding quietly.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Me, too.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Very good.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Next slide; Sarah, this one is yours.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

All right, so this is view, download and transmit and other than my standard comment about linking to the standard. And also if standards are proprietary, to obtain a limited license similar to what was done with SNOMED so that people aren't seeing their cost of development to get access to mandated standards, I ask that they put in the plain English description of the required CLIA data elements rather than making you go somewhere else to figure out what they are.

I had a question about the activity history so it's not new the requirement to track and make available to the end user information about who and when someone viewed, downloaded or transmitted, but this whole API requirement adds much more complexity. So I'm asking for clarification that the only action and information that is required for use of the API is that the API made a request call for the information because once that data passes to the API, the vendor has no knowledge of what happens with it or who sees it.

I wanted a lot of clarification here on how the testing labs are going to test this because if vendors don't already have APIs that have been created out there that meet the current standards requirement, is ONC or NIST going to develop APIs for each vendor that they're going to test? And certainly we would need to have immediate access to these products to begin testing. So, many vendors already have APIs that are used for certain functionality, but I would bet that very few of them utilize the standards referenced here. And then I mention again if you actually have a testing tool that works as it...as we expect a testing tool to work that the output should simply be submitted as attestation and not require a visual inspection. Others from my workgroup or from the larger group? I'd love to hear from the test labs to see how they're planning on testing these.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Well I would say...I'll add that the key thing in terms of on the API part, I mean our initial thought had been in a sense put it, I mean, since there's not a standard API out there, to kind of put it to the vendor to say, okay, you're...you need to provide this "receiver" of that, you know, this is the processing that...I mean, even if it's a dummy system right now, at least it kind of demonstrates this capability, which I know is a little odd but I don't know if there's any other...I mean, we can't just put a here's our API...here's our tool out here and everyone build to this API doesn't make sense either. So, honestly Sarah that was kind of my...our take on that, was kind of to put that forward to say, all right, you provide something even if it's kind of a test harness type of system, just to show that...we're open for other ways around there, but I don't know how else we can do it without prescribing.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I mean, once again, vendors, the last thing that we need or want to do is divert resources from creating products that our end users want into creating, you know, a dummy API to test only. So...

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

Folks, this is Andrey Ostrovsky; I...my perspective is, as often is the case is from the perspective of community-based programs and technologies in that setting. And I think this is an interesting theme pertinent to technologies that let's say vendors that support emerging interoperability standards out in the community setting and that's been discussed as somewhat out of scope for our conversations here. But I'm wondering if maybe not for this body of work, but as a note for future work, I think that maintaining flexibility in APIs is important but I'm wondering if there may be themes or general recommendations for let's say EHR communication to long-term supports and services providers, for example.

And there may be various use cases for that, but ultimately like...or standards that will be there for LTSS that are standards now for the...in the medical space where EHRs are supporting those workflows. Maybe for future work looking at the connectivity almost pathway from the medical setting to let's say the LTSS setting that could be grounds for creating some kind of not overly rigid standards, but some kind of standards and how those APIs are structured. Just as one way to potentially constrain things without constraining things too much.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well remember the whole purpose of an API is to allow other vendors or developers to create tools that leverage what functionality is in the EHR, so...

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

Um hmm.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...if there are not, you know, other developers that have created APIs for every vendor seeking certification, it is unrealistic to expect the vendor to create their own...to develop their own...

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

Um hmm.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...add-on tool because it's really, I mean, why would you need to use an API...

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...if it's an add-on tool to your software? Now, if, you know, I mean I know that for example, I think in our product we have someone that has created a student health scheduling software that runs on our product. But is that pulling all of the data that's in that core data set? No. So, we could say well, we've got somebody that's running an API, but it's not going to have all of the data that's mandated that we're supposed to be providing in, you know, via this API.

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

Um hmm. Yeah.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, I mean I think going back to, I mean, if we're talking about just the scope of the testing itself that's, in some ways actually an easier thing to come up with, I mean, you can put that together. I mean I think the harder part, I think what Sarah's getting to, at least I'm taking it from that is really...this is more a comment back to the regulation that if this is required, this is a lot of work for the vendors to develop this out. And once they do, I mean let's say they...so this is, you think you've to test this situation means that someone has developed this and then it's just a matter of kind of proving that.

So if they have developed an API, that's what they're coming in to, then they...to have kind of harness or some kind of tool out there that you would presume to have tested this already themselves or confirmed. So and I think we can allow for, you know, vendors to provide their own kind of...out harness, whatever to kind of demonstrate this, because again, that's what we're just demonstrating is that we can do different calls and stuff. There will definitely be some set up for that. I mean, I think we can get around it, it's...certainly the bigger concern though is just this, you know, the idea that everyone has, you know spent the time to develop this out there and it would kind of, obviously, help the industry if there was a common kind of, you know, API that everyone kind of aligned around maybe that people use. That's...API gets into your architecture, that's a hard...you can't just say here's the API, everyone use this. I mean, just from a testing standpoint though, I mean I think we'd have...you're going to have to be, gosh, I even ha...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Do we say not ready for prime time again, you know, it's the direction that everyone wants to go with FHIR, but because FHIR is draft standard, it's not called out.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

This is a situation where it might be appropriate to not do it now and, you know say please continue to work towards that.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, I was...I'll just say this, is it from a test lab? I mean, we...this is such a big thing that for us we just kind of say, you know what, we're not going to spend a lot of time right now thinking through this because if it does make it through the regulation and its final, then we'll deal with this. But I definitely don't want to spend a lot of time working on it right now and then it gets...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well, I mean I agree except I want everyone at ONC to be clear about the difficulty of trying to test something like this, so that they don't write it into the final regulation.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

I agree. Yeah, this would be a several...this would be a lengthy part of the test, I mean, you can't just casually...again, because it's not just here's the tool, send it to us. To some degree you're going to have to have this customizable and that's going to take some time.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Anyone else have anything for this before we move on?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Well to me, and this goes towards the regulation I know and not the test method and probably fits into Cris and Liz, we could say a lot category but the main thing about the API that would be of value is the ability for obtaining data from the consumer perspective, not so much that every providers now motivated to make available an API to consolidate the data, we're...that just recreates the issue we already have which is the proliferation of portal tools.

And it almost begs that there's a, you know, on the receiving end of this, maybe not so much testing the ability of a vendor App to consolidate it on behalf of a provider offered thing...I'm getting off track now. I could start going into the philosophy of we've just pushed down the problem to a different technical delivery platform of every provider making available a consume access point when really the point of the policy, from a regulatory standpoint is to give the consumer the ability to consolidate free and independent of all of the provider-specific delivery platforms that are out there. This area is in need of a step back, but that's just...

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

But...and I think going back though to...and obviously it's hard not to get on the regulatory part of this, but I think Sarah's comments though are...that the test procedure right now just kind of restates things. When a test procedure in this case, especially with this API should really be describing how are we going to do this? What would you need to do?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

And kind of, it just...it gets over...that's the hardest part of this, you know, how will...not just from a test lab side, but how will a vendor prepare for this? What will they need to do, set this...so, I mean I think this comment is, you know, as Liz is talking about, this is not suggesting,

this is reco...strong recommendation. We need to just update it to describe how you're going to test this, describe this and, we need some more detail here or we're just going to have to figure it out as we go, which isn't good.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

No, it's not good. It's...I'm sure all of us are a little, more than a little worried about it because it's out there in big letters and all of us are trying to figure out what the heck it means in real life, which is why I think you're comments about testing and that would...often that gives us a glimpse into how we might actually tactically get it in place. And I think we're in the dark, at least I am. So...we only have a few minutes left and we may need to keep going.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I...this is Cris.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

I mean...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Go ahead Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think the comments to a large degree are complicated but they speak for themselves and I think our group is behind them.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think we ought to let them stand as they are and move to the next topic, unless someone has any additions or changes they'd suggest.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I'd just ask that you correct the spelling of my last name on the slide.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That was...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

I'm sorry, Sarah.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, it shouldn't be a "Y," it should be an "EE;" I'm kidding.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Oh my, here we go.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

It's Southern.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Got it, so I just wanted to time check quickly and then we only have a few left and by my count we, one, two, three, four, five, six; there are like eight more to try to get through. And I know Dave Kates isn't on, so we have...we can probably skip to slide 9 if John wants to go through the e-Prescribing...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

...in the last few minutes we have.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

I think that one is relatively straightforward for the main point we'd want to make. So again we're reiterating, I think, as Sarah said, it's kind of standard comment here, so that first bullet's kind of self-explanatory. We do also think the test method, considering all the different transaction standards and specifications that are really being proposed here, it's fairly well the whole of the Medicare Part D e-Prescribing standard set, you know, what test method might be used, visual confirmation, conformance testing.

And I think it does go towards again reconciling the conformance testing between the specifications that are used for what is the mainstay production experience for most of us with Surescripts versus what is perhaps the purer NCPDP transaction standard, not to com...it's as much a comment on the selection and the specification for recognizing other testing methods to be relevant and let us attest to this if we have proven the ability to transact in the very same transaction from a Surescripts perspective.

I think we also, and this is as much a comment on the regulation as the test method, have some concerns about the use of this criteria to include a lot of standards that may not explicitly be required to meet the e-Prescribing measure of the objective for Stage 3. So, there...depending on how that lands, I would keep a footnote here to say, what is really required to meet the CEHRT definition and the e-Prescribing measure and what may be more in the realm of CHIT, if you're trying to perhaps meet another program purpose, like Medicare Part D, voluntary e-Prescribing compliance. That's not exactly in our comments, but I think it's important to reflect here.

And then the configuration and set up of the Test Pharmacy, how are vendors going to get pharmacy initiated messages into their system? What's going to be the external source? It's not real valid for the vendor to dummy something up to send to themselves and most of us have our testing environment set up to use Surescripts Test Pharmacies for that kind of purpose when we're talking about our own testing of e-Prescribing. So, those are the main things we would want to highlight.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

So I would just add that the RxFill is problematic; you're requiring something that pharmacies aren't sending right now. And I don't think that people have really thought about the workflows that might be engendered by, if you think about all of the prescriptions that a physician writes, about having to deal with messages coming from the pharmacy for every single one of those as to whether it was a fill or no-fill. The clutter, the messages in the inbox; I think that this is something that we need to wait until pharmacies are actually sending fill data and then pilot it and see what the implications are for workflow and where we think this is more important. As a physician myself, I really don't want to get fill messages, I'd prefer to get perhaps no fill messages; but I sure don't want to get a fill message.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Any other comments from anybody else? I think the main points here are both what Sarah said and then really again applying, I think, the principle of what is really in the definition of CEHRT out of this criteria and what may be optional and discretionary for other purposes. It's a pretty significant amount of work to meet e-Prescribing when the measure's based on really only two of the standards.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sounds right, John.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yup, I think we're good.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Okay.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great. And I think we'll need to probably...move to public comment, because we only have 2 minutes left. And we can work through...I can synthesize from the comments that were received today and then I'll work with Michelle to get those formally submitted to the Standards Committee for proper follow through back to us for receipt. And as I said during the last call, individual comments that were consolidated and were grouped together can be submitted to us directly through the website to our certification website where the draft test procedures are posted, so we can...we'll actually receive them and process those according to our standard process.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay, sounds good.

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

Thanks Scott. Lonnie or Caitlin, can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

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

We have no public comment at this time. So thank you, everyone.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, lots of good work, thanks everybody for all the hard work.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Pleasure.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Thanks. Bye.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks everyone.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Bye, bye.