



HIT Policy Committee Interoperability & Health Information Exchange Workgroup Final Transcript February 25, 2015

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – 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 Policy Committee's Interoperability and HIE 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. Micky Tripathi?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Here.

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

Hi, Micky. Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Good afternoon, Michelle.

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

Hi, Chris. Arien Malec? Barclay Butler? Beth Morrow?

Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership

Here.

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

Hi, Beth. Brian Ahier?

Brian Ahier – Director of Standards & Government Affairs – Medicity

I am here.

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

Carl Dvorak?

Carl D. Dvorak – President – Epic Systems

Here, Michelle.

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

Hi, Carl. Dave Whitlinger? Hal Baker? Jitin Asnaani?

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

I'm here.

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

Hi, Jitin.

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

Hi.

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

John Blair?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Here.

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

Hi, John.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies

Hi.

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

Kate Kiefert?

Kate Kiefert – State HIE Coordinator – State of Colorado

Here.

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

Hi, Kate. Kitt Winter?

Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration

Hi.

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

Hi, Kitt. Landen Bain? Larry Garber?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Here.

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

Hi, Larry. Marc Probst? Margaret Donahue?

Margaret Donahue, MD – Director of VLER Health (Veterans HIE), Co-Director of the Office of Interoperability – Veterans Health Administration

I'm here.

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

Hi, Margaret. Melissa Goldstein?

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

I'm here.

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

Hi, Melissa. Nancy Orvis?

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

I'm here.

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

Hi, Nancy. Shelly Spiro?

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

I'm here.

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

Hi, Shelly. Tony Gilman?

Tony Gilman – Chief Executive Officer – Texas Health Services Authority

Here.

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

Troy Seagondollar? Hi, Troy, that was Tony, I'm sorry. Wes Rishel?

Wes Rishel – Independent Consultant

Here.

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

Hi, Wes. From ONC do we have Jon White?

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

Hello, Michelle.

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

Hi, Jon. Lee Stevens?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Hi, Michelle.

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

Hi, Lee and certainly last but not least Kory Mertz?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Hi, Michelle.

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

Hi, Kory. Anyone else from ONC on the line? Okay, so this group had a little bit of a reprieve but back to work so I'll turn it over to you Micky and Chris.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Great, thanks, Michelle, hi everyone thanks for joining and as Michelle said we had a reprieve and now we're going to be back in the thick of it. Today we are going to start looking at the released ONC Interoperability Roadmap.

As you may recall we did have the opportunity to look at and weigh in on some of the preliminary draft work before it was officially released for public comment but now it's been released and what the FACA leadership has done is taken various pieces of the roadmap and assigned it to different Workgroups to dig into specific pieces.

So, the work that we're going to be focused on, as we'll describe in a second, is looking at the pieces related to patient matching and resource location and Kory is going to walk us through the specific pieces of the roadmap, some of the details and some specific questions that ONC is interested in having us engage on, but we'll talk about some, you know, logistics and administrative stuff to begin with just so you have a sense of the timelines and how this fits into the larger picture.

But first let me see, Chris do you have any introductory comments before we dive in here?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Yes, thank you, Micky, I'm very excited to get started on this new section and the only thing that I wanted to add to Micky's introduction is one of the things that I am hoping to hear today are thoughts and comments of the questions about those sections that we are asked to comment about, comment on if the questions and orders to this group are sufficient or if there are any additional questions related to those two sections that we should be answering. So, I hope we're going to have a very good discussion on that today as well.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes, great points, thanks. So, why don't we move ahead with the agenda. Next slide, please. So, in terms of the work plan itself we've got, you know, there was the Joint Policy and Standards Committee meeting on October 15th that, you know, took us all the way back to the JASON Task Force, Governance Subgroup that then led to our looking at the recommendations from the JASON Task Force as well as the Governance Subgroup in the context of the draft interoperability roadmap, which we provided some input to.

So, now it's been released, as I said, late January and there is also a FACA HIT Strategic Plan that some groups are weighing in on as well for providing comments on. And then sort of a near-term game for us I think is to be able to provide some comments on the interoperability roadmap for the April HIT Policy Committee meeting.

I think we'll provide preliminary thoughts on the March meeting but I think the expectation is that we'll provide our final comments in the April timeframe which will allow the Policy Committee to synthesize all the comments from the Workgroups and then formalize their comments I think on the entire interoperability roadmap for ONC.

In parallel there are the two NPRMs, the Meaningful Use Stage 3 NPRM and the Certification NPRM that are floating out there waiting to descend and drop upon us. So, that could happen and indeed is very likely to happen within the timeframe that I was just talking about here. So, you know, obviously that will be a, you know, very important thing for us as a Workgroup to be weighing in on as well, but I think we'll just have to figure that out once we see the release date for that and then the timelines are laid out from the Policy Committee on, you know, how they want to divvy up that work and when they want to get comments back.

Kory, anything I missed on the timeline here?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

No, I think you hit it all Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, great, thanks. Next slide, please. So, well, I think, all of you are familiar with the work that we're doing here. I think we got the able leadership of Kory Mertz from the FACA Workgroup side helping us with filling in the gaps of all of our discussions and providing the overall context.

The general questions that we're going to be addressing as it relates to, you know, the two areas that we're focused in on are, you know, are the actions proposed in the interoperability roadmap the right actions to improve interoperability nationwide, what gaps might there be, is the timing appropriate and does that make sense and are the right actors and stakeholders associated with the actions, you know, sort of identified.

As, I said we're going to be looking at identity matching and resource location, you know, we may in the course of that, you know, sort of see that there are dependencies on other areas that I think we should certainly flag and decide whether we think, you know, further discussion is required there. It's always, you know, very hard to carve this stuff up because so much of it is interconnected, but I think that's, you know, sort of something we can tackle as we go through this and identify such areas.

And then finally, there is a section specific question related to identity matching on just a, you know, just so you know the questions in advance of going through the materials, you know, in what ways does the draft approach need to be adjusted to sufficiently address the industry needs and address current barriers. I think that's going to come up again as Kory walks us through the detailed material. So, next slide.

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

Micky, can I make a quick comment? Sorry, this is Michelle.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, please, yeah?

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

I just want to...Lonnie if you can go back one slide, I just want to comment on why we broke up the roadmap the way that we did. For those of you who have seen the roadmap it's long and we just tried to be a little bit strategic about how we broke it up to make sure that Workgroups weren't overlapping too much with each other and making sure that each section of the roadmap was covered and there are certain sections that we knew would take up more time and we needed greater insight on. So, part of that is why this group has two sections which are actually more than some of the other groups were assigned.

And so we tried to divvy it up in a way that made sense and I'm sure that there might be some items that you feel that we've missed as Micky mentioned so we can talk about those as we go through but there was a little bit of a method to the madness just to give you a little more insight, thank you.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Thanks, Michelle. So, I forget, Kory were we able to add a slide on how that was divvied up across all the Workgroups just so we have a sense of, you know, the jigsaw puzzle?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, it's slide eight, Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, all right, so we're going to get there, okay. Next slide, please. So, I mean, I think...I don't think there is anything on this that's any different than what we looked at on the Gantt chart is there?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

No it just has the specific meeting dates that's all.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, next slide, please. So, I forget where we discussed you're going to take over? Is this the slide, Kory?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, I can pick it up from here Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, great, thanks.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Not that I'm eager to get off the stage or anything.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Well, thank you Micky and Chris and so with this slide we're just trying to highlight the process we're proposing to go through for reviewing these sections and gathering all your comments. I think we want to steal a page from the work of the JASON Task Force and the approach that, you know, I think worked really well with that Workgroup, of taking...you know, so we already have the assigned sections and we asked specific questions in those sections.

What we want to do between this call and our next call on March 5th is to have Workgroup members review the sections, look at the questions, draft up comments and responses to those questions, send them into me, Chris and Micky we'll then synthesize all that and that will be kind of the starting point for our next call on March 5th and that will lead us through our kind of Workgroup calls moving forward and really kind of provide some meat to start the conversation in these various sections. So, we want to have those in by March 3rd so we have time to get them ready for the March 5th meeting.

As Micky mentioned, Micky and Chris will be presenting to the Policy Committee in March, kind of the early thinking of the Workgroup on these two sections and then we'll be going back to the Policy Committee in April with the final recommendations. So, that's just quick on kind of the process we're proposing before moving forward. Any questions or comments on that at this point?

Okay, let's go onto the next slide. So, just...we're going to walk through, well I'm going to walk through very quickly a few background slides, a lot of this is material that you guys are already familiar with because we've already looked at the roadmap but just wanted to just have it in the deck and also just provide a quick refresher.

But just a reminder for process-wise where we are at this point with the interoperability roadmap. So, in January ONC released the kind of draft 1.0 version of the roadmap so that is out for public comment, that's going to be available for public comment until April 3rd and, you know, as we mentioned the FACA, you know, the different sections have been divvied up and the FACAs are looking at this. The comments are going to go back and then ONC is going to synthesize those comments, review them and release the 1.0 version of the roadmap later this year. So, next slide.

So, this is the slide I was mentioning before that shows how the various sections have been divvied up across the FACA Workgroups. So, you know, we can certainly talk about any questions on that later. So, next slide.

So, you know, again this is getting into kind of the meat of a lot of the interoperability roadmap and things you guys have taken a look at before, you know, I don't want to spend too much time on this. There are a couple of slides here and I'll hit on points where, you know, I think there are things we talked about before that, you know, I think will be helpful but just remind us again. So, next slide.

So, just to refresh everybody's memories, these are the three kind of goals that were outlined in the draft vision paper that ONC put out last summer and these really ground the interoperability roadmap and the kind of timeline goals, so, you know, for 2017 we want to make sure there is nationwide ability to send, receive, find and use a common clinical dataset. And, you know, so forth across the three kind of time perspectives. And then the five building blocks that were outlined in the vision paper and, you know, this content has really moved forward and I think it's a key framing for a lot of the roadmap. So, next slide.

So, you know, on here, just want to remind everybody there is the 10 kind of principles we used in, you know, kind of weighing and balancing the creation of the interoperability roadmap. One thing this Workgroup certainly talked a lot about I would say during our initial review of the interoperability roadmap and something I just want to make sure to, you know, hit on again, is that the goal of the roadmap is to establish a floor, a nationwide floor around interoperability and the goal is not to create a ceiling or to hinder innovation moving forward but really to create that kind of important floor functionality and capability across the country. So, again that's something I think we touched on quite a bit last time so I just wanted to make sure to reiterate that.

And the other piece, again, is that this...the interoperability roadmap is not, you know, the federal government's roadmap or a government roadmap but the goal is really to provide a roadmap for the whole Health IT ecosystem, you know, the public sector, the private sector, all the stakeholders so we can come together around a common approach to moving towards interoperability and the goals, you know, the broader health and healthcare goals that interoperability is going to help us achieve. Next slide.

So, these are the 14 kind of functional and business requirements for the learning health system. They have been mapped to the five building blocks and, you know, again, just wanted to show this as kind of a refresher for folks, you know, obviously if there are any questions on any of this, because I know I am going through it quite quickly, happy to kind of step back and talk through any of this, but, again, I think, you know, we talked through a lot of this back in December so I don't want to spend too much time on it. Next slide.

So, I'm going to start diving into the details of the two sections that our Workgroup has been assigned around accurate identity matching and reliable resource location. And actually I guess I should pause for a second and just see if there are any questions on kind of the overarching interoperability material if anybody has any questions or things they want to talk about at this point before we dive into the details?

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yeah, this is Brian Ahier, hi, Kory, and this is probably a question for the ONC and, you know, the charge from the HIT Policy Committee but also a question for Micky and Chris and that is, and Deven actually raised this as they were talking about dividing up the work effort here, and while they certainly asked us to respond to specific sections of the interoperability roadmap, she raised the notion that there may be areas that Workgroups might see that if they had the time and the bandwidth and the capacity to respond to may wish to respond in addition to what we've been specifically requested to respond to and I wondered if there was any thought given to potential other areas where we probably wouldn't have a, you know, fully formed comment process going on but where we want to make mention of anything outside of the two areas that the Policy Committee has asked us to comment on or are strictly going to focus our efforts only around those two sections?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, Brian, this is Micky, let me jump in and then provide some answer, and, you know, happy to hear from Kory as well. So, yeah, I think, you know, I agree, I think that it's really hard to, you know, sort of carve this stuff up and divvy it up and expect that we aren't going to be, you know, sort of touching on other areas and if there are other areas that we might think are, you know, genuinely important and where we could be helpful in providing some feedback and I think in general what we've...the way I've sort of thought of the FACAs and the ones that I've participated in is that we always want to address what ONC and/or the FACA leadership, the Policy Committee, has asked us to look at, so that's the minimal set we need to do those but anything additional is really, it seems to me, is a part of the Workgroup decision that we as a Workgroup if we decide that there are some other areas that we want to weigh in on that we should do that and we should make the time for it.

So, you know, I would say that we shouldn't consider ourselves limited to this but we need to make sure that we thoroughly answer these two things to make sure that we're answering the questions that were asked of us.

And I'll just put on the table, you know, one area that we didn't touch on that no Workgroup is actually addressing is governance and, you know, as Michelle said there are lots of reasons for the way ONC decided to, you know, sort of distribute these across the different Workgroups but that may be one area that's underlying a whole bunch of these things that sort of begs certain questions of governance that we may end up wanting to weigh in on at some level.

Brian Ahier – Director of Standards & Government Affairs – Medicity

That's exactly what...I agree with you completely that's...I was thinking that thematically interwoven into our answers to these questions there may be elements of governance involved.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Micky this is Chris...

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

So, this is Michelle...

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I apologize, but I respectively must differ a little bit from your view. I think it's very important for starters that we focus on those two areas that we are assigned and I think you said it well, this is the minimum we do and I think the timeframe that's allotted to us is pretty tight to really do a good job on those two items.

I don't disagree with you when you say we should if we...if a topic neighbors on a related section that we shouldn't venture out there, but I think that there probably was some decision making being made that leads the governance, at this point, out of the hands of the FACA. So, I would prefer to focus on the task that we've been assigned.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, I agree, I mean, minimally we absolutely have to do that, there is no question about it, but, you know, I would say as a FACA we're not restricted to any of this. We're an outside Federal Advisory Committee so and I think as Brian said, it could just eventually be that there is a subtext under all of this that touches on certain areas of governance that we end up touching on even if we don't say specifically, okay, this meeting, you know, down the road is focused on governance, we may end up just inevitably touching on those other areas.

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

This is Michelle, so, I think Chris pretty much said what I was going to say, but, as long...so as was discussed at the meeting when Erica first introduced the roadmap if you all could at least prioritize these two items and make sure that you leave time to thoughtfully think through these two sections because there is a lot in these sections and we understand that there may be other areas that you want to cover but if you could make sure that you thoughtfully review these first that would be our preference.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Absolutely, yeah, no, we have to do that I don't think there is any disagreement on that. I completely agree with you, these two have to be the priority. Okay, should we go ahead Kory?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yes, let's jump to the next slide. So, I'm just going to walk through...so both of the assigned sections for the Workgroup are in the core technical standards and functions building block so I'm just going to walk through two slides quickly on kind of a high-level of that section.

So, you know, this building block is really about the health information technology must be properly standardized, packaged and securely transported in order for meanings to be retained across systems and to be parsed and displayed in useful ways. So, you know, our two sections are two of the five sections in this area, other Workgroups have been assigned the other ones. So, we can jump to the next slide.

So, you know, this is just a couple of high-level points from these various sections, you know, first I think everybody is aware that as, you know, one of the first deliverables of the interoperability roadmap ONC published the kind of best available standards list and that certainly plays into a lot in this section and the areas that are talked about in here were best available standards are outlined in there so just an important thing to keep in mind through this.

This section also, across the board, talks about a number of areas where we think additional work around standards will be helpful, for instance, you know, more tightly defining the common clinical dataset, work around Consolidated CDA, data provenance and, you know, really advancing RESTful APIs.

And lastly, you know, kind of the high-level points of this section is around individual data matching which we're about to dive in a lot more detail into so I won't belabor the point there, but at this point I'm going to turn it over to my colleague Lee Stevens who is our subject matter expert on individual or on accurate identity matching. He's going to walk us through those slides, so Lee go ahead, please.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Thanks, Kory, I don't know if I'm necessarily a subject matter expert, but I have done a bit of work in this space and it's a bit like groundhog day because, oh, guess what patient matching it keeps popping it's head up everywhere and with the concept of a learning health system it clearly becomes much more important and much more complex in a 10 year timeframe.

So, on slide 17, if we can advance to that one, really what we're looking at here of course is that health information from disparate sources has to be accurately matched. We want to prevent fragmentation and erroneous consolidation of data.

You know as the learning health system evolves obviously there is going to be a lot more happening that needs to be matched, you know, provider identities, system identities will have to match, devices, public health and clinical research will come into the picture in a more meaningful way.

So, we're really looking at a much more complex environment which means getting those first stages correct and really getting everyone on the same page about where to head with those initial attributes because based on everything that I've sort of learned about patient matching over the past few years is it may not ever be completely done, we may always be improving the way that we match our identity whether it's in healthcare or whether it's how we aggregate our financial records or even about personal interest items, every iteration of technology seems to present a new opportunity to consolidate your life digitally and so it keeps morphing into new and more complex areas.

So, really looking under the Health IT strategic plan objectives here, obviously we need to identify, prioritize and advance technical standards that will support secure and interoperable health information and we're going to have to increase access to...and usability of high quality health information and services, you know, really focusing on that standards piece something that constantly comes up throughout the roadmap is the word "standardize" and that's something that I want to draw particular attention to on the next slide, on number 18.

When we think about the three year milestones and the key strategies for improvement, you know, we really need to standardize those data elements and we need to make sure that the quality...you know these two things are very linked because currently there...it's kind of shocking that the way that first and last name is entered on a C-CDA is not currently standardized and that's got to happen before we can look at data quality in many ways because people have to become familiar with what the standardized national agreement on what that's going to be and then we have to really punch hard at improving quality and keeping it accurate and we also need to of course measure the accuracy of the processes and identify where there are problems that we should be improving on.

The roadmap identifies obviously the following data elements, a lot of this is familiar, it came...some of these concepts came out of the work we did late in 2013 and work that has been done across time on patient matching clearly first and last name, previous last name, middle name, suffix, date-of-birth, current address, historical address, phone number, gender these are some pretty obvious elements that we need to get standardized that will improve things very much today.

There is obviously something that is always lurking in the background everywhere we go it comes up all the time, but it is not addressed here and I think everyone on this call knows the reasons why, but we'll see what happens with that. So, next slide, nineteen.

Really looking here at what the measures are number one, standards and best practices, again, in 2015 through 2017 in the near-term we really do have to be standardizing those minimum recommended data elements. We need to, you know, get query working just on a very basic level it needs to be very accurate so that we can start building in additional data elements and information silos that will sort of play out the learning health system over 10 years.

We also need to, you know, require that set of data elements in all individual identity query and record linking transactions. This is a place where, you know, free to be you and me does not necessarily work if you want to have a very unified system by any measure.

We also need to look in the next three years at the best practices that will help through patient registration, verification of patient information and updates and corrections to information. There needs to really be a clear understanding of what expectations are and then on top of that a very clear list of best practices and processes that support the standardization of those recommended data elements.

Finally, here's that word, governance that Micky and Chris were just discussing, you know, we are going to have to look at, in the future, what is going to hold all this together, what is going to keep everybody on the same page, you know, there is obviously work to be done as Chris mentioned to get us to that point to make some initial decisions and, you know, I think the hardest part will just be getting...if we can get everyone on the same page then governance may actually spring up somewhere who knows maybe I'm being...I should know not to be so optimistic after working Health IT for 10 years.

So, 2018 through 2020 really expanding the interoperability of Health IT and the users, we should be at a point where we're reliably including standardized identity matching data elements in transactions. We should really be using standardized attributes in standardized data formats to match individuals for coordination of care, for individuals that use and access their personal information, governance yet again, we will have to really look at those new elements for matching that we may learn more about in the future that may be more useful.

You know, as I mentioned earlier, it seems clear that patient matching may never be 100% solved for all time. It may just continue to evolve as technology does and of course that's more work for us, but if we're improving for patients and the community it will be worth it.

So, 2021 through 2024 providers and Health IT developers should use best practices for data quality and algorithms to enhance matching and at this point, obviously in the concept of achieving a learning health system 10 years from now, we're going to be looking at a whole lot more than just sort of a basic regional or statewide query which is something that we really like to do well on in the near-term for matching. So, on the next slide, on 20, measure two, pilots and further study...

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

May I ask a question?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Oh, sure absolutely.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I apologize, this is Chris Lehmann, so one of the things that I noticed to discuss on this slide were, you know, what gaps and specific actions, etcetera, and I was wondering, especially item three, whether there is room for discussion for different tools as well. In medical record number entry is notoriously flawed, there is a high risk of error for incorrect data entry and that's one of the things that makes it challenging to match patients appropriately.

When the check digit was introduced that is calculated from the actual numbers of the medical record number quality of data entry drastically went up. So, is there room to discuss additional tools to improve the accuracy of data used for matching?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Yes, Chris, and actually I think that's coming up on in the next category which is for measure two is pilots and further study. It may fit into that category or if we need to look at bringing it back to standards and best practices of course, you know, that's certainly open for discussion. Do others have thoughts on that? Micky, anybody else from the call?

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

This is Shelly Spiro with the Pharmacy HIT Collaborative, one of the things as I'm reading through this and it's kind of difficult for us in pharmacy because we sort of solved this problem quite a long time ago and that's my basic question, there is a lot of good examples within pharmacy where we have to, through regulation, whether that's through state boards of pharmacy and others, especially on ePrescribing, even our claims aspects, some of the Medicare Part D Program, of patient mapping all the way to prescription drug monitoring. So, there are several examples that have occurred in pharmacy of best practices on doing this type of matching. Is there any...are we going to be looking at some of those models that currently exist and have existed for many, many years...

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Right.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

In this arena?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

That's obviously a very good point, I mean, this...the work we did in 2013 when we came away from it we were like, hmm, well, you know, patient matching is hard and complicated but it's not rocket science, like it's been figured out in certain segments and I think it's going to be really critical for those examples of things that work really well to be brought up as we think about the piloting, particularly like if we want to think about piloting some of the work that's been done in pharmacy and seeing how that plays out in a regular clinical environment.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

And I'd like to add to that, I mean, this isn't just something that our proprietary solutions, these solutions have already been vetted through NCPDP, the National Council on Prescription Drug Programs, which is an ANSI accredited standards development organization.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Right.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

So, these are standards that exist today but just aren't mainstream in these types of discussions.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

I agree with you 100% they should come into the discussion because I think that...I mean, my personal perspective based on what I learned is it's pretty obvious, you know, the way that people have very accurately matched and created very high positive patient matching rates are by doing the really obvious things very well and honing algorithms to meet regional variations and for pharmacy that is something that has probably been done even better than it has in certain regional instances.

Wes Rishel – Independent Consultant

Wes Rishel, can I ask a question or make a statement here?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Oh, sure, absolutely.

Wes Rishel – Independent Consultant

So, I did my first patient matching system in 1984 it was done based on Bayesian algorithms developed at UC San Francisco and one of the things we've constantly struggled with in this area is that you don't know what you don't know in the sense that achieving independent evaluation of the effectiveness in terms of false positives and false negatives of patient matching is an extremely costly process so there are very few studies that actually independently verify this.

We are going towards a time where the feedback loop on failed patient matching is getting more tenuous because we want to use this information for learning purposes and things like that and I just want to encourage that pilots and evaluations take into account the difference between situations where you can and you can't apply regional variations because you're trying to do it on a national level and measure the effectiveness.

I'm particularly concerned that we are not paying attention to a process that's going on, on the Internet across all technologies, which is to involve the patient or the person who is the subject of matching in the matching decision, it happens all the time, I think it happens very well with some personal health records but in terms of the processes that happen at care delivery organizations when patients are registered I don't think it's happening and I think part of that is the reason that the government can't fund any work on a patient identifier.

We need to find ways within the limits that the government has to work in to explore all the processes not just start with the assumption that patient matching will always be based simply on a blind evaluation of demographic elements in computing a probability of match. Thanks.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Thanks, Wes, and you're absolutely right and I think one of the things in thinking about patient matching is some of the those demographic elements, whether those end up being the factors that improve matching for the very long-term there are still going to be very important elements to have standardized in a clinical document for patient continuity and for personal health records.

And so I think that those are all things from that very elementary starting point that, you know, as you mentioned as we get into this area of further study we will need to look at other things like of course biometric technologies which are really good and becoming very widely available and familiar to most Americans which is very, very helpful for people to have familiarity with these products.

Recognizing the amount of time I want to go to slide 21 quickly and touch on adoption. So, in 2015 through 2017 we really need to start coordinating and disseminating information on best practices, 2018 through 2020 we need to really look at a broad range of healthcare settings where this data is going to be important for the learning health system and in the 7 to 10 year timeframe all Health IT systems should continue to exchange data using the standardized matching elements and again through the governance or public and private stakeholder work we need to ensure that those data quality rates within the source systems and the matching services are meeting metrics that are acceptable for health.

And with that I will...

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Lee, this is Micky, would you mind flipping back one slide?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Sure.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, I'm just trying to understand what's in here and as I started reading the words again, I've read them a couple of times, but I started reading them which is dangerous I know, but it says, you know, like the first one through public and private stakeholders should develop and pilot tools and technologies for establishing performance metrics for individual identity query and internal individual matching record looking. So, is that saying that we want to be able to better measure accuracy and that's what that is calling for...

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Yeah.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

And a consistent way of measuring accuracy? So, it's not saying that we want...it's not saying anything about the technology that we're using it's saying that we just need a consistent way of measuring how we're doing regardless of the technology?

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Absolutely and sort of a standard measure for knowing what's acceptable, you know, this was one of the challenges at our work last year was, you know, we initially went in and said, well, let's look for 100% and that's actually not realistic.

So, we need to determine exactly what is acceptable, you know, we want to get to 100% in 10 years but in the meantime what is going to be acceptable for us to measure against and how do we identify the problems that need to be solved to, you know, hopefully get to 100% in the future.

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

Hey, this is...

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Does that...

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

Sorry, go ahead, this is Arien, I just want to get a comment in.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Oh, go ahead, Arien, I was just...I was going to say, you know, does that make sense that idea that we don't actually have an accurate acceptable limit currently established and we don't have a standardized way to measure.

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

Yeah, this is...so I'll comment on that specifically and then comment on the set of tactics and outcomes in general. Number one is that, and this was raised in the ONC stakeholder whatever it was on identity management, that I'm not sure what it would mean to have performance metrics for identity and internal matching and I worry that just like you have in real world performance metrics you'll end up with people teaching to the test.

I'd in general comment that identity and linking are reasonably well understood issues that the tactics that ONC is seeking to apply are good, better standardizing, the linking attributes and making sure that there is better clarity about how to use standards to get those linking attributes are reasonable tactics but that this is ultimately (a) a data governance issue and (b) use of additional matching attributes whether it be biometric or driver's license or the like. And that if you don't address the data governance issues you're not likely to make a really big dent in this area.

I'd also, you know, Shelly raised the issue of pharmacy, if you look at pharmacy you've got tight linking of data governance to payment policy and to other kinds of activities that are pretty critical for pharmacy success.

For some reason it's acceptable in a lab to collect minimal data identifying elements so long as you get a claim through but it's not acceptable to have enough data governance to make sure that you're...you know that you're taking a lab draw for the same patient that you drew six months ago or in a hospital it's somehow acceptable to put a duplicate in because you've got to have your registrars registering a bunch of patients and you can't get in the way of their workflow because they're about how you get paid.

And I'm wondering why payment policy and other kinds of government levers aren't on the docket relative to the upstream issues that actually cause issues in patient matching and linking.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

That's another...

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry...this is Larry, I was actually going to comment about that.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Oh, yeah, Larry, go right ahead, yeah.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Were you just suggesting that pharmacy does a good job of getting it right?

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

No, what I was suggesting was that payment policy, as Shelly was commenting, that in pharmacy you need to collect a certain amount of information in order to get a claim through and that this claim, that information is actually required for getting real-time claims adjudication. So, there is a business practice that encourages pharmacy to check identifying information because they don't get paid.

And what I'm suggesting in general is that the patient matching and linking issues that we have in healthcare are often secondary to data governance issues where it's acceptable to duplicate register a patient so long as you get your claim through and that it's not acceptable to spend the extra time in registration making sure that you've reconciled the patient because you're actually reducing registration, you have to add expense in the registration step in order to improve data quality but that's acceptable and there is no payment policy levers that say that's not acceptable for example.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Yeah, I agree with that.

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

Yeah.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I agree with you on that I guess I've been...and one thing I have notice and Shelly, I apologize, but, you know, we've been taking claims data in real-time from, you know, the claims that have been fed from the pharmacy through the PBM to the health plan and we take them right into our records and we've been shocked at the mismatching that has been taking place and when we study it, you know, a lot of these are, you know, juniors and the thirds, you know, father/son kinds of things and occasionally twins, and we've been surprised that most of them are occurring actually at the pharmacy level.

So, you know, there is a...I do look forward to, you know, determining measures of what the current rates and what we ought to be, you know, shooting for as an optimal rate, you know, short of 100% because it's a big problem out there.

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

Yeah, and again...

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

Yeah, if I can respond, this is Shelly Spiro, I agree to the level of claims and Arien it's not just about the claims there are other regulatory requirements in relationship to matching that are not just claims related that don't necessarily follow through the claims process that Larry is bringing in, in terms of receiving that data.

There are things that are happening, as an example, through prescription drug monitoring programs, through other regulatory requirements with actually the script itself that are not necessarily...lead to the development of a claim.

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

Yeah and I don't want to have an argument about whether pharmacy is better or worse, I think the point here is that there are specific data governance requirements...

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology Collaborative

Agree.

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

That are tied to some of the other regulatory oversight functions that the federal government has or state governments have that may have a much bigger impact on matching and linking than standardizing data elements and I'm not saying that to say that standardizing data elements isn't a good thing, it's just to say if your registration processes are a mess you can standardize all day long and, you know, you'll just have a slightly cleaned up mess.

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

Yeah, this is Nancy Orvis from DoD, I would agree with Arien and Wes Rishel. I think what I'm hearing coming out is we should...when we write our additional information in this area that we should stress that there is actually talking to the patient themselves in almost real-time consolidate are you who you are that's what I hear Wes Rishel.

And the second I hear is that this group might consider recommending other than ratcheting down on data elements to exact better patient matching, that there are other alternatives that should be put into play as well as that. That's what I hear and I think that's a very powerful lever right there. How do you keep people from doing the duplicate registration right off the bat.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Well...

Wes Rishel – Independent Consultant

I think just to elaborate on that a little bit, the system I built actually measured the clerks to see how often they made dubious matches or dubious decisions that this is a new patient and provided feedback to the medical records administration and is probably the single most ignored program function that I ever built.

Lee Stevens – Policy Director, State Health Information Exchange Program – Office of the National Coordinator for Health Information Technology

Well, there is a lot of healthy discussion ahead on these topics. I want to defer back to Kory quickly just to see if...how much more time he needs or if he wants to continue a dialogue at this point?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, I think if there are any last questions or comments on this I think we have time to take those but yeah I want to make sure we get through the reliable resource location piece as well. So, any other comments or questions, or thoughts that folks want to share?

Okay, great, I mean, obviously we'll have a lot more time to talk through these issues, but I think that was a great initial conversation and Lee thank you for walking us through that. So, can we go to the next slide, please? Next slide. Great.

So, moving onto reliable resource location, so the, you know, we define reliable resource location here at the ability to rapidly locate resources including providers, individuals, APIs, networks, etcetera by their current or historical names and descriptions. You know and I think we see this as an important concept for the learning healthcare system, the ability to find and locate services, you know, provider's addresses, etcetera.

This section, you know, just to be clear here, this section is not necessarily about finding an individual patient's information per se, but more about how to find an API or a provider directory or another service that could maybe help you get to that next step but it's not necessarily about directly finding their patient information, that's how we've kind of structured it so just an important, I think, point to raise at this point. So, next slide.

So, the...I'll walk through the various elements, just reminders of kind of questions that are at the top here, you know, the questions we've specifically outlined for these sections, you know, obviously as you're going through the comments template you're not limited to these questions, these are just questions that we've asked across the board in the roadmap so they're ones we're very interested in understanding feedback on, but, you know, obviously similar to our last conversation if there are things outside of these specific questions or you have thoughts and feedback on, you know, these sections we definitely want to hear that as well and need to get it in the mix.

So, you know, there are two kinds of...there is N1 and N2 in here and I kind of think about them a little differently. So, this first chunk of kind of actions I feel like is more looking towards the future and thinking about what needs to happen to get us to where we want to go, you know, long-term with the learning healthcare system and the second set of items is more focused on kind of the what we have in the near-term, how do we build off that for now and then is that right for kind of plugging back into this first one to pivot to the longer term.

So, the first milestone is really focused on coordinated governance public and private process through that really coming together to identify the architecture and workflow for resource location as part of the learning health system including looking at individuals and IT system actors, roles and access requirements.

So, and then, you know, the second area in here is really, you know, so we'll define this overall architecture and kind of workflow then figuring out, you know, I think we recognize with any kind of endeavor like this prioritizing and starting, and building in a piecemeal manner is, you know, often very important to the success to these sort of things.

So, you know, a key second step for this is really prioritizing where this work should begin and how we build towards the kind of more long-term vision of what we need to be able to provide to meet the learning healthcare system requirements for reliable resource location, so, you know, starting out with that long-term vision and then identifying how do we prioritize the steps on the pathway to reach it.

So, kind of the third prong of this piece is really having, you know, once the architecture is out there having standards development organizations and Health IT developers really pressure test and look at the standards that are out there today and see if they can meet the kind of architecture and priority needs moving forward and, you know, maybe the standards that are out there today can, if there is some modification to them. I think those are the types of conversations that need to happen here or, you know, I think after going through this process there could be a determination that what's out there today isn't going to meet the needs and we need to develop some new standards, new APIs, etcetera to really make sure we nail the reliable resource requirements.

So, I'm going to jump to the next slide here because there is a couple more on the 2015 to 2017. For the future timeframes 2018 to 2020 and 2021 to 2024 we're really looking for feedback on what those milestones should be moving forward just to make sure that's clear to everybody.

So, you know, kind of the next bucket of this is really focused on the policy framework for resource location, you know, I think in today's world I think one area we see this a lot in, you know, when I think about resource location one example that, you know, I think is very tangible to people today is around provider directory, you know, and I think we see as the ecosystem is working on provider directories that there are a lot of policy issues depending on how you implement your provider directory are you creating a federated ecosystem of different directories, do you have a centralized directories, there are a variety of different policy issues that pop up from that. We expect, you know, a similar set of needs around these reliable resource location services and so, you know, there is going to need to be a process developed and kind of the policies outlined for how to, you know, appropriately implement this to make sure the systems are secure and that we're addressing issues like data quality, etcetera in these resource location services.

You know and again, I think the next step is really also kind of back on the standards point, you know, I think something that's stressed throughout the roadmap is, you know, focusing on, you know, testing and piloting standards and so, you know, I think that's going to be an important piece here as well for the more longer term resource location piece.

And then, you know, lastly and this kind of to me ties the two sections together, as we were thinking about the future for resource locations it's going to be very important to develop a glide path from where we are today to where we need to get to in the future because certainly folks who have a lot of infrastructure in place today and how do we make sure what folks have today can happen within the future as well. So, next slide.

So, this is kind of transitioning to that second set of communities in the research location bucket that's again more focused on some of the near-term stuff. So, you know, as kind of a near-term and interim step ONC is recommended to continuing to work with current provider directory activities to advance networks, you know, I think we've seen in recent years a lot of interest and activity around provider directory and provider directories.

You know obviously one area in particular there has been a lot of interest in this is in the Direct space and the Direct community, you know, specifically for transitions of care requirements for Meaningful Use Stage 2, you know, a lot of organizations are looking at provider directories as the easier way to find the addressing information of other providers that they want to exchange information with. So, you know, I think we see an important role there to continue to advance that work as we kind of long-term figure out what all this needs to look like for the learning health system vision.

ONC is going to...one thing outlined in this section of the roadmap is some exciting work that CMS is doing with NPPES, their NPPES modernization work, it's got a number of facets but I think some of the most interesting for the kind of resource location work in particular is that one they're looking to expand the data elements that are included in NPPES to also include items such as a Direct address or other electronic service information for providers.

They're also looking at creating a RESTful API and, you know, adding some more functionality that hopefully will help providers make it easier for providers to update and maintain their information such as providing delegation of authority so they can have others in their offices do the information updating.

So, for this in particular, you know, ONC wants to work with CMS to make sure the work going on with NPPES is also compliant with some of the existing provider directory standards in place today, in particular HPD and also as I mentioned to add Direct addresses and other ESI information into NPPES.

So, the other kind of activities in this are...I would bucket them in two areas, one is really around, you know, working to improve certification and testing abilities around provider directories whether that features the site tool or through other kind of certification programs, I think there is interest in that.

Then also working with our federal partners to coordinate their work and activities around provider directories and kind of resource location in general but, you know, again kind of with a lot of the focus today in this space, from what I'm seeing, is around provider directories. So, that's the 2015 to 2017 piece.

Looking to kind of the next phase the 2016 to 2020 the focus is again really on kind of bringing these people together I would say from the near-term, okay here's what we've got today, to the long-term vision of where we need to go for the learning health system. So, you know, really focusing on picking what the standards are going to be in the future, outlining, you know, guidance and best practices around data quality, maintenance and updating the information in these services.

So, that's kind of a high-level overview of the reliable resource location, happy to take questions or have a dialogue here.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry...

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

This is Arien, I'd like to get myself in the queue, Larry obviously got in first.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Okay, thanks Arien. So, one of the things that I find missing here, which is one of the problems that we deal with is keeping the directories up-to-date and you talk about, you know, policies and best practices to keep directories, you know, maintained and up-to-date, but I think we really need to make sure that we also include technological standards to keep them up-to-date, you know, the reality is that, you know, if you want to know where providers are working and what their Direct addresses are and when they leave, if they leave their Direct address should no longer be pointing to that place and, you know, I've long believed that the electronic health record that we use is probably...knows better than anybody else, you know, where a physician works and when they no longer work there.

And that wouldn't it be wonderful if there was this technology and standards that my electronic health record is automatically keeping a provider directory up-to-date with who is working where, when and that no one has to manually do this, we don't need, you know, manual work to keep things up-to-date and I think that's an important piece that's missing from this that it's more than just policies, keeping it up-to-date there should be technology standards.

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

This is Arien, I struggle with this section because it seems to be based on fiction and somebody wise once told me "practice before policy." The notion that we have ubiquitous provider directories lots of people are doing it and we know how to do it and, you know, we've got to get maybe more of it done, we know the standards that are applicable and we seem to get people to use it more seems to me not to be consistent with what's going on, on the ground.

I think in particular, and this is a policy...we're on the Policy Committee side, but I think in particular on the Standards Committee side we've heard HPD mentioned a number of times and the judgment of the Standards Committee is that we haven't seen enough adoption and use to even have a judgment as to whether it's an appropriate standard for use.

And in the area of resource location, which is something that I believe very strongly in and, you know, applaud ONC for focusing on the business need, I think we're so far from figuring out what the appropriate patterns are that, you know, I struggle for example with listing things like CSD as a best available standard because as far as I know I don't even think it's been trialed in a connect-a-thon much less put into production, I could be completely wrong on that, but it seemed to me to come out of nowhere.

My general comment here is that the timeline here just to me seems rather aggressive relative to the actual practice that we have in areas of provider directory and resource location.

And I guess the secondary comment is that there are other ways to skin this particular cat. So, for example, in CommonWell we embedded resource location in with the provider...I'm sorry the patient location query because we felt that this was the appropriate time to give somebody the location was in context of looking at where the patient location was. So, and again, not to say that's the solution, but to say that we haven't even explored what good practice is much less what best practice is, that it seems to me very premature to think about standards adoption and coordinated governance to get wider use of something that we just don't know what it is.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

So, Arien, just one thing to mention, HPD is what's called out in the standards advisory not the other standard that you mentioned.

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

CSD is called out in the standards advisory.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

It is? I thought it was...

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

Yeah, it's in resource location and it's on the section for best available standards and implementation specification for services page.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

All right.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

This is Micky, I completely agree with what Arien has said. I mean, just because...that's a criticism that many of us have had of the standards advisory is that it's advising on things that aren't widely adopted in the market.

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

Said positively, because that may have sounded negative, I think positively, you know, I really applaud ONC's focus on provider directory, I really applaud ONC's focus on resource location. My general comment is that we need to have practice to establish at least good patterns and good practices before we're ready for setting a floor relative to broader scale adoption and utilization.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

And I guess building on that, this is Micky, you know, we did, as many who are on this Workgroup a couple of years ago may remember, we did a lot of work on provider directory and ideas around provider directory and one of the things that we did recommend a number of times was that CMS do something just in the opendata.gov, you know, sort of spirit to the extent that they have better, you know, or more comprehensive data than any single source might have they're putting something out there that people can start to use or not use if they find that it's flawed would be a great first step. So, I think it's terrific that they're seriously doing that.

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

Yeah, I'd point out actually the NHIN Workgroup way back in the day in 2010 did a hearing on provider directories concluded that governance and linking, again I don't mean governance in terms of, you know, top down data use policies, I mean, data use governance and linking data quality to operational practices was a critical success factor in order to drive this and definitely pointed at CMS although noted that the provider directory information was sufficient to get paid may not be terribly relevant for where care is actually delivered because in some cases you've got billing offices and others or you've got multiple locations for care.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

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

So, to the extent possible I'd actually encourage ONC to look back at that NHIN testimony because we had a lot of it and it was very good and I don't think anything has changed in the five years since then.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, I'll also just note for those who are interested in looking back at some of the...I'm not sure if that specific one is linked in their Arien, but in the appendix of this slide deck there are links to a lot of FACA recommendations around patient matching and resource location.

Carl D. Dvorak – President – Epic Systems

And I think, this is Carl, I think we get a lot of air time around provider directories, but I still suggest that the institutional directories might be more important. Providers move around and so many patients are cared for by the provider of the moment they may not even remember after the fact in an ED or in another care venue. So, I do think we should keep an equal focus if not a greater focus on the institutional level directories.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

And I forget, I mean, I recall one conversation we had a couple of years ago where, you know, someone had suggested, it might even have been you Carl, I forget, who had just said if CMS just put out a CSD file every day.

Carl D. Dvorak – President – Epic Systems

Yes.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

You know a whole industry would develop around cleaning up that data then they don't have to figure it all out.

Carl D. Dvorak – President – Epic Systems

Or tie it to the Meaningful Use attestation data.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Right.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

All right, other thoughts or comments on this for today?

Kate Kiefert – State HIE Coordinator – State of Colorado

So, Kory, this is Kate Kiefert from Colorado. I think that that's the same thing that we were talking about with the identifier space for the patient before that there are kind of three different things that are kind of happening here, there is something that needs to happen at the operational level of entering these things and then there is the technical level with that, sometimes some institutions might do this manually and some might have a source system that they're providing this information in so what are kind of the impacts we could trickle into some of the, you know, the deeper levels of where the information is coming from.

And then there is also just setting the policies and the governance and I absolutely think that this can be mimicked in saying if there is a way to set a standard, not necessarily mandate, but set a standard at a state level with Medicaid and say, okay, this is how we need all of our information to come in for providers, then, you know, you can absolutely mimic that here.

And there are a few things that we're doing in Colorado with our workforce, our health workforce where we are setting up the governance structure with public health and licensing but also with the HIEs so that the work...the scope isn't necessarily all foresee a provider directory and we're pulling in the payers but also the institutions and seeing if there is a way to do the...kind of a federated query and fill in the data gaps because I don't think that every single place is going to have all of these...every single possible desired data element. So, that's the way we're kind of working around these things.

And, you know, I always will go back to operationally what are we...in setting these are there any unintended consequences down to an operational level and how do we factor that into the long-term plan.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Great, I think that's going to be a great perspective to bring to this and inform the comments for this so thanks Kate.

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

Kory, this is Michelle, I'm just looking at the time and want to make sure that we have time to talk about next steps and open up for comments.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, so unless there are any final comments we should probably move onto just the next steps slide.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Okay.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Can we jump to the next slide, oh, well sorry, actually go back one. So, this is a comment template, we can send this out again just as a kind of separate file but this is in the back, you know, the second appendix of this deck it has each of the kind of actions broken out and it has a section for the comments and then the questions at the top. So this is what we're hoping folks can take the time to go through and provide comments and send them into, again, me, Micky and Chris by March 3rd. If we can jump to the next slide?

And so then we will take and synthesize those comments and have them ready to start the discussion on the March 5th Workgroup call. So, Micky, Chris, you know, are there things you want to add to that or do folks have questions at this point?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

This is Micky, I don't have anything to add, I mean, I think, you know, giving people...this is a great introduction Kory so thank you for walking us through that and it would be great to get, you know, people's comments so we can, you know, synthesize when people have had a little bit more time to think a little bit about it. I think that process seemed to work well with the JASON Task Force and hopefully it will work well and be convenient for people here.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I wanted to echo the thanks to Kory and the ONC staff for this.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Okay, great, well do you guys want to open it up for public comment then?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes, please.

Public Comment

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

Caitlin, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

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

So, while we wait for public comment Kory are we going to send out an updated deck with just the comment slides on them?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, yeah.

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

Okay.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

We'll do that after this just so it's easier for everybody, yeah, we'll send an updated deck with just the comment slides.

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

Okay, so be on the lookout everyone and it looks like we have no public comment.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, great, thanks everyone.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Enjoy the warm weather.

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

Thank you, have a great day.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thanks a lot.

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

Thank you.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Bye everybody.