



**HIT Policy Committee
Interoperability & Health Information Exchange Workgroup
Final Transcript
April 2, 2015**

Presentation

Operator

All lines are now connected.

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? Arien Malec? Barclay Butler?

Barclay P. Butler, PhD – Director of Health Standards & Interoperability – Department of Defense

Present.

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

Hello. Beth Morrow? Brian Ahier?

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yes, I'm here.

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

Hi, Brian. Carl Dvorak?

Carl D. Dvorak – President – Epic Systems

Present.

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

Hi, Carl.

Carl D. Dvorak – President – Epic Systems

Hello.

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

Dave Whitlinger? Hal Baker? Jitin Asnaani?

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

Present.

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

Hi, Jitin. John Blair? Kate Kiefert?

Kate Kiefert – State HIE Coordinator – State of Colorado

I'm here.

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

Hi, Kate.

Kate Kiefert – State HIE Coordinator – State of Colorado

Hello.

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

Kitt Winter?

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

Here.

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

Hi, Michelle.

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

Hi, Larry. Marc Probst? Margaret Donahue? Melissa Goldstein? Nancy Orvis? 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.

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

Hello.

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

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? Is Tony here?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Troy is here.

Tony Gilman – Chief Executive Officer – Texas Health Services Authority

Yes.

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

Okay, both Tony and Troy. Wes Rishel?

Wes Rishel – Independent Consultant

Here and my rooster is here as well.

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

That was you, hi, Wes.

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

Wow, we're getting desperate for Workgroup members aren't we?

Wes Rishel – Independent Consultant

Generally he dissents actually.

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

It gave me a good giggle so thank you, Wes. Kory Mertz from ONC?

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

Here.

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

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

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

Yeah, hey, Michelle it's Lee Stevens.

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

Hi, Lee.

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

Hi.

Catherine Costa, RN, MTM – Innovator-in-Residence – US Department of Health & Human Services – Office of the National Coordinator for Health Information Technology

And Catherine Costa.

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

And with that I'll turn it back to you...I'm sorry who was that?

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

Hey, Michelle, it's Arien, I'm on.

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

Hi, Arien.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

And Hal Baker, I'm on too.

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

Hi, Hal.

Catherine Costa, RN, MTM – Innovator-in-Residence – US Department of Health & Human Services – Office of the National Coordinator for Health Information Technology

And Catherine Costa, sorry, guys.

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

Hi, Catherine.

Catherine Costa, RN, MTM – Innovator-in-Residence – US Department of Health & Human Services – Office of the National Coordinator for Health Information Technology

Hi.

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

Okay, we'll turn it back to you Micky.

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

Okay, great, thanks. Hi, everyone thanks for joining. We're going to be diving into...this meeting is going to be the last meeting that we're going to talk about the interoperability roadmap and we'll talk about the schedule going forward. So, thanks for joining. Why don't we jump ahead here? Chris Lehmann is not...I don't think is able to join us today so...

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

Actually, Micky I was here, I responded to Michelle, but it seems like she didn't hear me.

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

Oh, okay, great, thanks, Chris. So, what we're going to be covering today is...you may recall that one of the things that we had talked about wanting to weigh in on is this question of should we recommend a minimum accurate individual identity matching dataset given that the roadmap has a suggestion based on, you know, a lot of work that ONC has done and the sense of the group was that, yeah, we want to provide some perspective on that and we may have some recommendations. So, we'll talk about that first.

And then we are going to finish up the reliable resource location comments that we got comments from a number of you, thank you for providing those, and we'll talk about that.

And then finally, we will...oh, right and then we're going to talk about prioritizing the identity matching critical action items because one of the things I think that we talked about was, you know, sort of the general sense that a number of us had that there were too many critical action items in the first time period, the 2015-2017 and so we had asked people for feedback on, you know, which ones ought to be moved if we have a sense that some ought to be moved so we'll talk about that. We'll also talk about the schedule here in a second. So, why don't we go to the next slide?

So, as I said, we've got the final conversation today about the roadmap and then Chris and I will be presenting our recommendations to the Policy Committee on April 7th so this Tuesday coming up.

And then we had a call of the Co-Chairs, the HIT Policy Committee Workgroup Chairs and Co-Chairs just two days ago I think with Paul Tang and we were given assignments for our next round of work which is going to be, and I'm sure it surprises all of you to know this, we're going to be weighing in with comments on the NPRM, the Meaningful Use NPRM.

So, the section that has been assigned to us is the...I think it's objective seven, which is the health information exchange section. So, there is...for those of you who have read that already there is a lot of stuff in there. It sort of has a pretty broad sweep in terms of health information exchange and interoperability issues both with respect to approaches, technology standards as well as there are questions in there that CMS posed asking questions about governance and how governance ought to or not be related to, you know, sort of Meaningful Use and performance and health information exchange. So, there is a lot of stuff there for us to grapple with.

There is a compressed timeline, unfortunately, so we need to get comments to the HIT Policy Committee on May 12th and so that means that we're going to have...there are two meetings on the books right now, as you can see, they are April 17th and April 30th for this Workgroup, but we're going to be adding a third that Michelle and Kory will be trying to figure out when is a good date for that. So, that will give us three full meetings to be able to go through the NPRM.

So, obviously, one thing that we're going to have to do is set some priorities because even with three meetings it is going to be a pretty short period of time. So, one of the things that we can think about, and we can talk about this at the end maybe, is each of us, you know, just going through the NPRM if you haven't read it already the Meaningful Use section, it's only 700 pages in its entirety both the Meaningful Use and the Certification Rule, so if you haven't read it I'm just wondering what is you do with your time, but if you haven't read it you can just read the objective seven section and then maybe we can...obviously a big part of the first meeting will be to set our priorities inside which things we want to weigh in on over the...for the time period that we have.

So, pretty heavy agenda that we have here for the next month or so. Are there any questions on the timeline? No, otherwise we can dive right in. So, why don't we go to the next slide? And next slide.

So, as you may recall, you know, we sort of deferred this conversation but the interoperability roadmap has a recommendation in it about what the minimum dataset ought to be for accurate individual data matching and this is the list here that we see and one of the questions...and you may recall also that one of the...we told the Policy Committee in the last meeting where we were providing our preliminary recommendations that we would be weighing in on this and one piece of feedback we got back was how does that line up with what Meaningful Use certification already requires of vendors.

And so one of the things that we've done is on the next slide, I shouldn't say we, Kory has done, for us is on the next slide has kind of taken that list and then, you know, sort of looked at from the 2014 edition certification of those fields, which are in the left column, that were recommended in the roadmap, which ones are actually already a part of a certification requirement. So you can see that column there.

And then he has also added what's in the current 2015 edition NPRM, which is draft, but it's in there under the "create a transition of care summary" requirement. And so, you know, at a high-level you can see that certainly for the 2014 edition not many of the fields that are in the interoperability roadmap are actually required to be a part of a certified EHR, more of them get populated in the 2015 edition certification and then some of the issues that we're all familiar with like current address, historical address there is, you know, that sort of open field right now, I mean, there is not, you know, standardized approaches or value sets for those and there are different conventions from different places of how you deal with the issues of O'Reilly and, you know, O'Donovan and all those kinds of things, Jr., Sr. all of that, but they do include those in the NPRM even though they are not standardized.

The one thing I would add is that at the bottom please note that there is an addition in the 2015 edition NRPM requirement for a transitions of care summary that adds place of birth which is noted there on the bottom of the column, that wasn't in the recommendation from the roadmap which is why you see it down at the bottom of the column. So, first off, Kory, is that an accurate description of what you've done here?

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

Yes.

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

Okay, great.

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

And, Micky, this is Chris, if I may...

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

Yes.

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

Make a comment, one of the things that as a neonatologist who deals with patients of ambiguous genitalia there is a big difference between gender and sex, you know, sex being your primary physical characteristics belonging to a sex whereas gender is your social and perceived role in society, so, you know, the differentiation of those two is I think critical, we should select one or the other. I would be in favor of gender but I don't like the mixing of those.

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

Yeah, that's an interesting point, so what does...I haven't read...in certification what does it say in either the 2014 or 2015 edition?

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

So, just to clear that up, in the rule it is sex not gender. Gender is what's called for in the roadmap...

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

Yeah.

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

But the rule is actually is sex so it's male/female or unknown I believe is what's in the 2015 edition.

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

Right, I think that's right.

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

Yes.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

So, it's either birth...type or X, Y...

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

And the distinction between those is that sex is the biological makeup, and I'm reading this here from Wikipedia, of an individual's reproductive anatomy and gender comes from the social roles based on the sex of the person usually, so those are, you know, very different especially depending on if somebody has a gender that is not congruent with their sex characteristics.

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

Right. There...somewhere else in the rule, and I can't remember where it expands the categories for gender and was that...maybe that was just a...was that a part of questions, Kory do you know? I mean, it wasn't...it obviously wasn't required for a transition of care summary but I know they do have this discussion somewhere in the rule.

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

I don't...I'm not sure, Micky.

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

I can look.

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

Okay, yeah, all right, but the point is it's not a part of a transition of care summary right now what is in there is biological sex.

Wes Rishel – Independent Consultant

Which I think Chris is trying to distinguish more...I mean, he's trying to get us up-to-date in terms of where medical practice is and we've always had to balance this against the administrative uses of the same field.

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

Right.

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

I wonder if there is...this is Larry, I wonder if there is a role of prioritizing some of these so for instance, you know, current address, you know, do we...even having the zip code, you know, is valuable at least to localize someone to a region of the country for matching purposes even if you don't have the full address and, you know, the other is for instance phone numbers. The mobile cell phone has more matching credibility than a home phone versus even a work phone.

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

Wes Rishel – Independent Consultant

This is Wes, I was thinking the same thing particularly with regard to cell phone now we have different things we've looked at, this is matching roadmap to certification and then we had some other documents that mentioned cell phone, it would be nice if we could sort of have a master list of all the different places we're looking at or maybe it's just easy to look at two documents.

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

So, the other document I think is probably from one of the recommendations from the Privacy and Security Tiger Team is that what you're referring to?

Wes Rishel – Independent Consultant

No, I think I'm just trying to find it.

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

Yeah, so the other two documents...

Wes Rishel – Independent Consultant

Accurate individual data matching, it's the letter...I think it's the...

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

The Power Team...

Wes Rishel – Independent Consultant

The worksheet for the letter of transmittal.

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

It was...the other recommendation is the Power Team that's the letter that came from Jon Perlin and John Halamka.

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

Oh, okay, right, all right so that was the Standards Committee side, yeah.

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

Yeah.

Wes Rishel – Independent Consultant

But anyway I think...certainly I know for me the most accurate historical matching phone number is my cell phone number and no one else has had it for a long time, I hope.

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

And...

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yeah, this is Brian, I think cell phone numbers are becoming increasingly important as identification data element, you know, I can wave my phone to pay for things now and, you know, my cell phone number identifies me more clearly than a lot of these other demographic data.

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

So would the...so just stepping back for a second, let's just...before we dive in and let's just hold...just pause here for a second. In terms of general approach does anyone...do we feel, as a group, that this list here in the 2015 edition NPRM that it's basically a step in the right direction, I mean, it's a good list, it doesn't have historical phone number, but it addresses all of the other categories that were listed in the roadmap and it adds place of birth so that could be one recommendation to say, we agree with the list of things here.

And the second would be if we have refinements to any of them then providing additional recommendations on refinements like the gender/sex question, like current phone number should be mobile phone number or we should add mobile phone number as a specific category to allow people to have home phone number or something like that.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yeah, I think add it.

Wes Rishel – Independent Consultant

This is Wes, again, the current language on our screen essentially covers that implicitly in the sense of more than one is present in the patient record all should be sent.

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

Yes.

Wes Rishel – Independent Consultant

I think we have some issues between what goes in a transition of care summary and what is an element that is used in patient ID matching algorithms but I have a sense that the practice in industry is going to lead towards getting cell phone numbers when they're available for all kinds of practical reasons.

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 and to that point, Wes, in the actual standardized approach that's in the NPRM for the 2015 edition it does specifically call out cell phone numbers or allowed home and business. So, there's a few different categories within it of what the phone number could be.

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

Just to add that detail.

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

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

This is Arien, I'm confused and maybe just because I haven't obsessively re and re-read the rule, I'm confused by "create a transition of care" and the common core dataset, the C-CDS, I'm doing that just because it annoys certain people to have another CCD something...so I wonder if...Kory if you or somebody else can comment as to whether the dataset that's required for create a transition is separate from, different from the common core dataset in the certification, the 2015 certification NPRM?

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

Yeah, sure, they are not one and the same Arien they're separate requirements.

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

So, with respect to access via API and the relevant sections that point to the common core dataset we'd be looking at a different set potentially of included data? And I might suggest, if the answer to that is true, I might suggest that we actually...(a) that's really confusing and (b) that we might want to consider both of those sets with regard to our recommendations.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Right, right so that could be another column.

Wes Rishel – Independent Consultant

This is Wes...this is Wes, I think we should consider a stronger statement which is that all of the data elements listed in the right column here be included in the common dataset.

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

So, one thing I would just keep in mind for this, we are talking about the interoperability roadmap. I think this is a really important conversation, I think you could have it potentially as part of the rule review as well...

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

But, I'll just throw that out there.

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

Yes, yes, no that's a good point Kory.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

This is Hal, since this is for the electronic health record there are a number of required elements that are also in there such race, language, ethnicity, height, drug allergies are there other things that we...non-demographic values that might be used with higher relevance matching than things that change like address.

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

This is Shelly Spiro, along those same lines one of the things that we identified when we did some of this work in PDMP was an optional field of an identifier that one might use between two entities. So, it's more optional but if it is available then it needs to be called out.

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

And another suggestion, this is Chris, is e-mail address which was in past work the one that, by the Power Group, that I cited earlier, they suggested e-mail address as an additional identifier.

Wes Rishel – Independent Consultant

This is Wes, in the recommendations there is...for the roadmap, there are recommendations for some research to validate potential new matching areas and I think all of these sound good but it has been my experience that some things that sound good validate better than others.

So, one possibility might be for us to look again at that list of the data elements subject to verification and see...and even as I remember the language it allows for new data elements, but I would like to suggest that we sort of focus our thoughts into two streams one is roadmappy and it involves some research and validation, and the other is regulatory and looks at nominal inclusion of well-established patient identifier fields.

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

So, let me just sort of see where we are here. So, we began this with, you know, a thought that we would want to weigh in on the minimum dataset and so...and now we have...and then we got a comment from the Policy Committee that, gee don't recommend anything...or, you know, we would be reluctant or at least some members would be reluctant to think about adding, as required, minimum data elements for patient matching things that EHRs aren't already required to capture for other purposes and so that's why we have these two columns here.

So, but from what I'm hearing there, you know, maybe more questions about, well getting at this minimum dataset isn't actually an easy conversation. We talked about, you know, well, gee there is race, ethnicity, language, e-mail. Well I think you're suggesting that, well there is more research that could be required here on, you know, what would be that minimum dataset and maybe we shouldn't be jumping to that kind of conclusion.

If we think that there is, you know, significant...that we're not in a position to affirmatively state, here are the 11 or we, you know, we affirm what the interoperability roadmap has suggested, you know, I would suggest that we sort of generalize a comment that essentially says that we think more work is needed or what is in the 2015 edition NPRM cross map to that is a great place to start but we can't say anything more about the specifics.

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

And this is such a complicated issue, this is Arien, I'd also point out that even if the EHR has the field facilities for editing and maintaining some of this information it's generally the case that the information comes from upstream in the process, usually from the practice management system or patient accounting system and so you need to take into account the full sort of data lifecycle or data governance lifecycle with regard to the recommendations for certified technology but also with regard to the recommendations for actual practice and how services that may use this data need to accommodate for data validation.

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

Right.

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

I'm just trying to make this a little more complicated, but, hopefully more grounded in the real world.

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

Right. So, let me just put the question to the group here. The roadmap makes a recommendation about, you know, that's on the left-hand column here, that there should be a minimum dataset and they make a recommendation about the minimum dataset.

We, in our last go around with this, we had some policyish kinds of things that we said about this question of identity matching which we can carry forward and some of them are, you know, I think Arien you had brought up a thing about, you know, that all of them shouldn't be required, whatever that minimum dataset is you can't require that every single one of those be used, but that can be a goal and, you know, and certainly considered a best practice, something like that, so we had a number of things that were of that nature, you know, that I think that we can put as recommendations.

But, it seems like we have this binary question here in front of us, do we want to say that the roadmap minimum data elements are okay as calling those a minimum dataset without making them required for patient matching or do we want to say they're not okay and then if we say they're not okay what do we want to say about that?

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

Minimum does definitely imply required, no? Sorry, this is Arien. I read minimum recommended as the set that should always be passed and maybe it's the set that should always be passed if available, but with regard to those terms I would definitely read minimum as implying required.

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

Right, right. So, maybe that's a good first thing for us to note is that...is just this question of that we don't believe and it sounds...anyone please tell me if they don't agree with this, that we don't believe that it makes sense to have a minimum dataset, a minimum recommended dataset for patient identity matching which has a corresponding requirement that says that every time you try to do patient matching you are required to have these fields and use these fields.

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

Correct.

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

Does anyone disagree with that as a principle? Okay, so it sounds like from a policy perspective we can say that.

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

And Micky also from a policy perspective I think we should endorse the notion that collecting and curating the recommended data elements is a joint activity that takes in both policy, governmental policy recommendations, many of which will be outside of ONC's purview...

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

Yes.

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

As well as business practice and best practice recommendations relative to data governance at individual settings of care.

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

Yes, yes and I think we had something like that in the earlier recommendations that we didn't bring forward into this conversation, but we'll, you know, sort of retain those, because we also had something that was stating to...that for particular use cases it may not make sense and also for...which is what you're pointing to, different business arrangements it may not make sense or sorry...

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

Micky this is Larry...

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

Data sharing arrangements.

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

Well, this is Larry, I just want to go back the statement you just made a second ago saying that there should not be any minimum required data elements but I think you actually do have to say first name, last name and date of birth are always minimum required. I'm not sure how you could do a transaction without that even if you're sending, you know, a medical record number you still need to validate against something else.

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

Plus gender I would say.

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

Well, I mean, that helps but if you're saying, what's an absolute minimum.

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

I'd say gender in a clinical situation, you cannot match people on a patient record without gender.

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

If there's a medical record number and I match two out of three on first name, last name and date of birth I'm actually...that works for us.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

And some people are different genders depending which office they're going to at what time of the day.

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

This may well be true, this is Arien, I'd also note that in our practice if a medical record is provided we use a range of demographic items to cross validate the medical record number, in some settings of care the upstream system will guarantee to us the medical record number actually does match the patient.

So again there is tremendous nuance and I endorse what Larry is saying but I don't even think that's a minimum, I think there may be cases where you do a date of birth check as a sanity check but you well trust the medical record number that's passed to you in stream because they've got business practice that ensures that medical record number is correct.

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

Right.

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

That makes good sense.

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

Yeah.

Carl D. Dvorak – President – Epic Systems

And Micky, since I think we're all in agreement on and it makes sense to say some could reasonably be a minimum set, I do worry about the historical stuff. I wonder if that's going to open up a Pandora's box of unintended consequence in terms of how that would be treated and trickled down into everything else. I think where one has historical addresses it makes sense. It kind of boggles my mind to think of a person at a front counter trying to put in three or four addresses that they've lived as, you know, people move around quite a bit and get the zip codes right and all that...

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

Yes.

Carl D. Dvorak – President – Epic Systems

I would...I like the idea of having a minimum but I see the historical on here and I wonder how that will be interpreted by later steps in the process.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Right.

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

So, but...yeah, so, I mean, it sounds like where we're headed though is to say that, you know, that we don't think that a minimum...that we can define a minimum dataset right now.

Carl D. Dvorak – President – Epic Systems

Well, I think the...this is Carl again; Micky, I think there are two purposes one is what's a minimum set to find somebody and the answer is no one is really sure because a birth date on Maria Gonzalez in Northfield, Minnesota is easier to find than a same birth date with Maria Gonzalez in Los Angeles.

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

Yes.

Carl D. Dvorak – President – Epic Systems

It is just the finding of them is always hard but I think there is the notion of a confirming set and you might find what is a minimum set to achieve what one would believe is reasonable confirmation and that could be a street address, date of birth, name, plus or minus middle initial and gender or sex.

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

This is Arien, I think that's right on and I think the specific worry is that if we describe something as a minimum dataset the temptation is to embed it as a certification approach and that misses the nuance that we're trying to say, which is that there is a best practice in collecting, curating and providing this information.

A certification requirement may well not be the appropriate policy lever to get the outcome that we're looking for, in fact may be counterproductive for exactly the reasons that Carl is mentioning and may actually require disruptive or check the box oriented kinds of processes to meet the specific requirements.

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

Right, so, I wonder...

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

I think that...

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

Yeah, I wonder if it makes sense for us to think about framing our recommendation actually by completely flipping the view to say that it appears that if we look at the, you know, the 2015 edition NPRM and match that against the recommendation of the interoperability roadmap that enough of the data elements would be captured for other purposes in the EHR and there is too much variation in the market in terms of, you know, how...under what circumstances that first step of, you know, identifying and then confirming that's reason specific, location specific, business specific and so we would not recommend that we...well, what we would say is that it appears that the NPRM is having the EHRs capture that data and how those are used for patient matching is going to vary a lot and we don't think that there is a single cookie cutter rule that one could put on that to say that this minimum dataset is what you need in any and all circumstances.

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

So...

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Micky...Micky, this is Hal, is this a minimum dataset for what purpose? Is it a minimum dataset before matching should even be attempted if that's all that this there or is it a minimum amount of data that you need to build your system to be able to transmit presuming that you got it and if you don't have it you don't transmit or is it just the goal that this is what we should aspire to before we...when we build a system.

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

Yeah, which one are you talking about the roadmap or the NPRM?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I guess when we're talking about it here.

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

Yeah, so it's two different things, I mean, what we're...so the roadmap is what we're talking about on this call, next call will be on the NPRM, but on this call it's the roadmap and there it's a recommendation that these ought to be the minimum data elements for patient matching.

You know what's required in the NPRM doesn't say anything about patient mapping, it...I meant patient matching it says that for a transition of care summary those are the data elements that you need and all we're pointing out is that a number of the elements that have been identified by the roadmap for patient matching are actually already going to be captured for other purposes in the 2015 edition NPRM.

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

Micky, this is Chris, two points, so first of all the point that sometimes you only need two data elements to match somebody that...I think Carl said that earlier, is well taken. I once got interviewed anonymously for a book and I was coded with my first name which is fairly unusual in my profession and people identified what I had said just from those two data elements. So, there is no such a thing as a minimum to identify an individual person.

But for the purpose of our task here I think with the goal here to say something about the dataset that we would like to be able to be exchanged in order to maximize data exchange and allow accurate matching of patients.

And I think the point that we should do...we should make is that we like what's in...that we principally like that data elements in the roadmap because they're fairly congruent except for the historical phone number with the 2015 edition of the Notice of Proposed Rulemaking, but we also should say that we like the fact that...and I appreciate Kory you picking up on that, that the NPRM adds the place of birth. I think it would be a gimme if we added this because it's going to be part of the core dataset anyway so why not use it because it will help in the matching. So, I think that's the direction we should go because that will avoid the different lists that will provide congruency and it will make work for the people who actually have to do this easier going forward.

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

Yes, anyone object to that?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

No, good idea.

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

No, okay.

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

This is Margaret Donahue from the VHA.

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

Yes?

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

And I guess the only perspective I want to put in to counter some of the collection of the additional information is the burden that it does place on, you know, the individual physician offices. I think that when I reflect back to us having to start collecting language and, you know, preferred language and race it was a pretty big task to change, you know, behavior in front offices and collect that data.

So, I for one am concerned about this whole algorithmic approach to patient data but I do know that it's the only way we can go, but I just want to remind us to think about the effort that's involved in collecting all this extra data.

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

Yeah, no, I think that's a good point and I think where we've landed here is to say that we don't think that it makes sense to say that it should be a requirement for patient mapping, for patient matching, sorry, I keep saying that, for patient matching that you have a full and comprehensive list, whichever one it is, of minimum data elements for patient matching.

What we're saying is that, you know, the more you have of those the better, but it depends on circumstance and some of the circumstances maybe that you just capture the data, you know, whether you use them or not.

What we're pointing out is that the 2015 edition NPRM will require that systems have the ability to capture this data should it be provided that's all we're saying.

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

Yeah, that's...

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

So, we're definitely...so we're not saying that we agree that there should be a requirement that you cannot do patient matching unless you have these 16 fields of data or whatever it is, we're definitely not saying that.

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

Okay.

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

Does that address your concern? Okay.

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

Well and I guess the other just, you know, sort of recommendation as we try to think of some new out of the box way of doing this...I mean, not out of the box, but, you know, new way of looking at this in general beyond the algorithmic approach for patient matching.

I know I'm not allowed to bring up the idea of the national patient identifier, but, you know, there is something more that we need to do because I think this is really a patient safety issue and, you know, match rates are not that great based on algorithms right now, I mean, they're not 100% by any means.

So, you know, codes...even if it's a small amount that's not matched, you know, there is certainly a patient safety issue around that.

Wes Rishel – Independent Consultant

Is it reasonable to say that we're focused on the roadmap right now and the roadmap calls for a combination of some issues to be planned for and others to be investigated. I would certainly hope that those investigations would look at a number of issues including the one that Arien has raised several times now which is the importance of the practices used in registering the patient as much as the data itself and work that's going on in industry right now in that area and that to me, you know, compared to where we are on the policy side that work is out of the box, I mean, it's not just adding another data element and so forth.

So, I think considering that we're on the roadmap now if we make the point that Micky has called out about sort of recommending not required but as available use of some extra data elements and we encourage the variety of approaches being investigated then we probably have done the best for the roadmap. This is Wes. Is anybody there?

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

Oh, I'm sorry, I was on mute, I was just saying that I would like to call a question here and it sounds like we've actually come to, you know, sort of a consensus view of this which is that it shouldn't be a requirement that, you know, Wes I think you just said it, that it shouldn't be a requirement, you know, having a list where organizations can mobilize whatever is appropriate from that list is better and that it looks like the certification rule is going to capture...is going to have systems be required to be able to capture this type of information so that it would in principle be available to those who want to use, you know, more and more of those elements should they choose to and should the business and governance case warrant it and the use case warrant it.

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

Micky, this is Chris, can we add to that data elements that are required to be documented that we recommend that they also should be available for patient matching.

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

I'm sorry, I don't think I got the first part Chris?

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

The data elements that are already are required to be recorded, so for the 2015 edition column on the right...

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

Yes.

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

That we recommend that these data elements also should be available for any patient matching efforts.

Wes Rishel – Independent Consultant

This is Wes, I think that exactly as worded that's fine, we need to be careful that we don't let that extend to being required for use in patient matching efforts.

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

Right.

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

That's reasonable to me, but, you know, they should be available for that. So, and I think that's a compromise that I think I suspect from what I've heard we can rally around.

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

Does anyone disagree with that or have a concern about that?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

So, I'm understanding that the sender must try to send that if they have it but the receiver can try a match if they have a smaller subset coming for some reason?

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

You got it.

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

Well, yeah, so I guess I was going to step it back just one to say that the system should make these elements available for patient matching should the user want to use those elements for patient matching. It is not saying that the user should use them it is saying that the system ought to make them available.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Okay.

Carl D. Dvorak – President – Epic Systems

This is Carl being one of the guys that sits on policy calls and standards calls...

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

Yes.

Carl D. Dvorak – President – Epic Systems

And then sits and looks through 700 pages of what they all turned into, I think unintended consequences is sort of my biggest thing lately.

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

Yeah.

Carl D. Dvorak – President – Epic Systems

So, I like the idea I just...I want to be careful that we don't see that idea blossom into a host of unintended consequences that complicate life for caregivers and their support staff, because I do think with some of these things it could get unwieldy pretty quickly because these rules are kind of being written in a hurry by people who don't experience them.

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

Yeah and I certainly had that...and Wes I think expressed that caution of, you know, we say that but will that, you know, unintended consequence be then that turns into a certification requirement for patient matching, then that turns into a use requirement for anyone who is going to do patient matching and all of sudden we're at a place where we're specifically saying we don't want to be.

Carl D. Dvorak – President – Epic Systems

And we have flipped into certify just in case we might need it mode lately, so I do have even a lot of fears about that.

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

Right, so we could actually put that, you know, in the recommendation to express clearly that, you know, that there is a bright line that we believe shouldn't be crossed here.

Wes Rishel – Independent Consultant

So, I'm trying to come up with a fairly terse statement of what we're all struggling with here and I think it's something like we think that additional data elements where collected for other purposes may be used for patient matching by systems and may be transmitted among systems for the purposes of patient matching where the patient matching algorithm can use the data, in other words, no requirement to use it, no requirement to collect it, but a requirement to be able to transmit it if it has been collected and then no requirement to use it once it's properly transmitted, but at least it got there.

Carl D. Dvorak – President – Epic Systems

It sounds though Wes like you'd have to presume whether the other side could use it or not and the...

Wes Rishel – Independent Consultant

No I'm suggesting that you send it if you have it...

Carl D. Dvorak – President – Epic Systems

Okay.

Wes Rishel – Independent Consultant

And the other side uses it if it wants it.

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

Right, I guess I would agree with that it's just the required part that I would suggest that we just soften.

Wes Rishel – Independent Consultant

Well, I'm only...the only place...I was careful only to put required in, in terms of transmission.

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

This is Arien and all of this becomes problematic only if we interpret it as a certification criterion. I think many of us learned from painful experience that such things often become certification criteria.

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

Yes.

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

I'd actually, from a policy perspective, recommend that the best way to implement this is in best practice and may even, and I've mentioned this a number of times, may even be in upstream activities that relate to more appropriate tools of government relating to for example inclusion of data in an 837 relative to a claim not in relating to HIT certification criteria.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yeah, this is Brian, I would agree with Arien, I think some language around that this is...we would recommend that this is the minimum data element that would be useful for patient matching as a best practice as opposed to certification requirements would be in order.

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

Right. Okay. Okay, so I feel like I've got enough here that, you know, I think we have that caution and it seems like we're all, you know, appropriately concerned about the unintended consequences pathway here but we would like to, you know, sort of motivate people to use as much data as appropriate to be able to get as accurate matching as possible.

Okay, all right, now I'm going to call the question and suggest we move to the next topic, so if we could move to the next slide, please?

So, I think Kory this is where you've tried to capture some of the comments from the last call?

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

Yes, from our last call, Micky, trying to kind of summarize the discussion and make sure this is reflecting what everyone feels like was the consensus from the last call.

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

Yes, yes. So, the first one relates to...I think we had a discussion about the sequence of actions as you may recall seemed appropriate but there was just a question of how far down that sequence could we possibly get in 2015-2017 and part of that was, you know, just a genuine concern about just the complexity of all of this and the collection action that would be needed in a very heterogeneous and decentralized industry and a part of it there was also something related to resources that people were concerned about to the extent that ONC or other government entities or any organizations would have resource constraints around this.

And then there was a concern about having anything related to targeting things that are supposed to be about the learning healthcare system in the 2015 and 2017 timeframe because we haven't yet, you know, sort of concretely and operationally defined what a learning healthcare system, you know, would really look like or mean on the ground.

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

And if folks want to see N1 through 5 they are the next slide, just, you know, if folks want to refresh their memories on what those are.

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

Oh, great.

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

Actually should we just flip to that for a second? No, no, no not there, forward, okay, terrifying, okay. All right, so and what we're seeing Kory is that 2 through 5 we thought should be moved out is that right?

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

Yes and then one I just showed the modification to the language.

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

Yes.

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

I just thought people would want to see all, you know, the five.

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

Yes, right. Does that make sense? And I think it was Larry it was your thought at the time that, you know, certainly within 2015-2017 timeframe we ought to be able to think about and identify the architecture and so that makes sense to keep in the 2015-2017 but everything else really ought to be moved out.

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

Correct.

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

All right. Does anyone have any concern with that? It seemed like we had a pretty good consensus around that. No, okay, let's move, next slide, oh, wait a minute, I think actually we need to move...there were two other bullet points in that previous one. Yes, back one more. Okay.

So, the second bullet is about focus on use cases, I guess we did have a conversation about thinking about resource location in very general terms whereas like with a lot of this stuff it is highly use case specific in terms of what appropriate resource location might mean.

All right and the third point is related to the resources and resources being a constraint in terms of how quickly we could move down that sequence of events. Any other...

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

And...

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

Go ahead?

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

This is Margaret again...

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

Yes?

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

Can you...I don't think I was on the conversation about resources being related to use cases can you give an example of what you mean by that?

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

Yes, so I'm trying to remember the conversation. So, I guess in general it would be that, you know, sort of the question of what resource location means and the level of granularity that you would need for it is highly dependent on the use case.

So, if we're talking about resource location being in the nearer term being a provider directory I guess one example would be does that have to be at the individual level or the entity institution level and you can imagine that there are some cases in which it doesn't make sense for it to be at the individual provider level whereas in other cases the institution entity level is completely appropriate and that's all you would need.

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

Okay.

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

So and assumption that you could, you know, sort of say there is one way of looking at reliable resource location is not really accurate because it depends on the use case.

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

Okay, thanks.

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

This is Nancy Orvis, I had a question on whether, given all these projects we didn't want to be any more specific about which resource location ones we really did want to see a solution for within the next two years or the next five such as provider directory. We didn't want to be...we don't want to be that specific in any of these recommendations?

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

Well, I think what we were focused on...maybe we should flip to the next slide again then, is to say that in this timeframe, 2015-2017, you know, we are agreeing, you know, generally with this recommendation from...or the critical action I guess it's called, from the roadmap which says that we need a process, an engaged process to identify the architecture and the workflow so some of the details that you're talking about, but that's as far as we've...that's as far as we've sort of been, you know, discussing this is not about making specific recommendations about what it should look like but reacting to the roadmap that's being proposed here and how much of that makes sense.

Are there any other concerns, questions or does...do people want to get into more detail on this? I don't think...we didn't sort of have that as our...as a part of a scope here especially given the time constraints that we have, we sort of limited ourselves to thinking about the critical actions as they were constructed and commenting on those not about going beyond where the critical actions were going.

Okay, why don't we move to the next one then. And next one, this is a comment about the next slide, right Kory?

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

I didn't include those since it seemed like from the last conversation everybody was pretty comfortable with the N2, those are the ones focused on provider directory.

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

Oh, okay.

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

I mean, that was my interpretation of the conversation.

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

Right, yeah, as I recall I think that's right, but we don't have those here, right? But we did get feedback and we had a pretty high degree of consensus I think.

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

Yes, yeah in the initial feedback process there was a lot of consensus on the last call we walked through them and, you know, people seemed to be in general agreement.

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

Right, okay, so, hopefully all of you are in agreement with the thing that we say you're in agreement on but which we haven't shown you the details of on this slide. Okay.

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

Speak up or forever hold your peace right?

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

Sorry?

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

I said speak up or forever hold your peace.

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

Right and just remember this was the roadmap, next call we're starting the NPRM that's the real stuff that has regulation behind it. So, okay, is this...was there anything else beyond this, I forget?

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

Yeah, so...

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

Oh, yeah, yeah, yeah.

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

Yeah, if you wouldn't mind just walking us through.

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

Sure, so first thank you to all the Workgroup members who sent in their comments. I was a little surprised by the outcome but of the eight critical action items and the accurate individual matching section that we were looking at for the 2015 to 2017 timeframe seven of the eight, based on the feedback that came in, people were supportive of keeping in the 2015 to 2017 timeframe.

There was one milestone in particular that's highlighted on here where there was kind of an equal reflection of folks who thought it was okay to keep in the current timeline with the number of people who thought it should move. Then there was one person who thought it should be taken out of the roadmap altogether.

So, that particular milestone where there was kind of a disagreement was M2.1 and it's through coordinated governance public and private stakeholders should develop and pilot tools and technology for establishing performance metrics for individual identity, query and internal individual matching/record linking.

So, that is the summary of what kind of came in through the comment process from the Workgroup members.

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

Okay, anyone opposed to pushing that...recommending that milestone be pushed out?

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

I think it seems logical, you know, if you start developing this and putting this into place, measuring right away seems counterintuitive.

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

Right. Okay, why don't we...

Brian Ahier – Director of Standards & Government Affairs – Medicity

Just to be clear, Micky, so you're suggesting that we move M2.1 into the 2018 to 2020 timeframe?

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

Yeah.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Okay, yes, I'm all in favor.

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

Okay. Okay, great, well I think that covers the interoperability roadmap if I'm not mistaken, right? You don't have anything else hidden behind here do you Kory? I don't remember anything.

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

No that's it.

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

Okay, all right, well, let me first off thank everyone for your help with this and for your input on this. And I'd like to make a suggestion for the next...because we're going to have three meetings now, so the first thing is you should see an invite for another meeting, and I know we're going to have to contend with HIMSS in terms of the scheduling, but we will be adding another meeting, and what I would like to suggest and this will be a little bit of general homework for everyone is to read at least objective seven...it is objective seven isn't it Kory?

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

Yes.

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

The objective seven section of the CMS Meaningful Use NPRM and, you know, I would also suggest reading the certification rule, the different elements related to health information exchange. I know the certification rule is a little bit harder to read through because it's not sort of logical in order as the NPRM is, but...and I have a version that I've done very high-level annotation of with some bookmarks to at least flag the different certification topics if anyone would like that, you know, please feel free to e-mail me and I'm happy to e-mail it to you, it has like 15 bookmarks, if you haven't gotten it at all, you know, you're trying to wade through a 350 page document with no table of contents, so, you know, I'm happy to send that out to people if that will make it easier.

But I would recommend that you look at least at the certification pieces that relate to interoperability as well to help the understanding and then one thing that I'm going to suggest doing is perhaps putting out and I can work with Chris in advance, a recommendation or at least sort of a recommendation or a strawman for us to consider in the first meeting what are the things that we want to focus on over three meetings and how should we, you know, sort of schedule those three meetings to address that framework. Because as you'll see there is a ton of stuff in there and we're just going to need to be very focused on what we think are the priority areas that we want to weigh in on as a group.

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

I'm delighted to work with you on this and before we move on Micky I just wanted to thank you for walking us through the slide set and for another very successful session today.

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

Oh, great, thank you. Okay, great, are there any other general comments? No, okay, Michelle, I think we're ready for the public comment.

Public Comment

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

Lonnie, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

Yes, 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. Thank you.

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.

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

Okay, great, thanks Michelle, thanks Lonnie, thanks Kory and thanks everyone on the Workgroup.

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

Thank you, everyone, have a great rest of your day.

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

Thanks again as well.

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

Thanks a lot.

M

Bye-bye.

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

Thank you.