

**HIT Standards Committee
Implementation Workgroup
Transcript
April 4, 2014**

Presentation

Operator

All lines are bridge with the public.

Michelle Consolazio – 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 Standards Committee's Implementation 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. Liz Johnson?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Here.

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

Hi Liz. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Here.

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

Hi Cris. Anne Castro? David Kates?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Here.

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

Hi David. Gary Wietecha? John Travis? John Derr?

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

Here.

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

Joe Heyman? Hi John.

Joe Heyman, MD – Whittier IPA

Joe Heyman is here.

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

Hi Joe. Kenneth Tarkoff? Kevin Brady? Michael Lincoln? Micky Tripathi? Nancy Orvis? Rob Anthony? Stephen Palmer? Sudha Puvvadi? Tim Morris? Tim Gutshall? Wes Rishel?

Wes Rishel – Independent Consultant

Here.

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

And do we have Mike Lipinski from ONC?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes.

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

Hi Mike and I think we also have Lauren Wu from ONC and Kim Wilson from ONC.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Here.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Here.

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

Thank you and with that I'll turn it back to you, Liz.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great, thank you, thank you everybody for attending. We are – if we'll go to the next slide please, we are continuing with terrific amount of work being done and work to be done. So, you can see here on this slide that on the 12th or 13th excuse me, we accomplished our task at hand and then on the 21st Wes did a remarkable job of getting us through a number of additional criteria and this morning we will have or this afternoon I should say, depending on where you are, we will have a final review of the summary from those four criteria.

And then Wes will continue to lead us through the remainder of the criteria from the meeting that was scheduled for the 21st along with the beginning of the review that will be, as indicated on the next slide, which says today, and Mike and his colleagues from ONC will lead us through these conversations which will include both electronic notes, family health history and then our public health measures.

So, our hope is that we will move through that quickly. Michael will give us a summary and then you can see of course what we have going forward. Michael will give us a summary. I would like to ask the committee members or others to please submit any questions or refinements to that summary to Mike and to Michelle, Cris and I so that we can make those.

We have a lot of ground to cover today and we want to be sure that we get through it. So, we won't have a discussion about the summary of the comments we'll simply have an explanation via the prior slide and then Wes will begin to lead us through the next set of criterion. And with that, I would like to move to the summary slide please. And Mike will you take it?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure, so hi, this is Mike Lipinski with ONC, believe it or not the government is not insoluble so if there are errors you find in this, as Liz said, please let us know and we'll make those revisions or additions.

So, we talked about transitions of care and spent a significant time on that. I think everybody can see the slide here, the main points I think were that, you know, obviously the ability to exchange bi-synchronous exchange or asynchronous exchange I should say, bi-directional exchange of the CDA, particularly a 2014 edition certified product would have difficulty being able to accept a CDA that was formatted to release 2. So, that was pointed out.

Obviously, there were some issues pointed out about the edge protocol IG not being constrained enough and then the performance standard that ONC had proposed I don't think anyone on the Workgroup could think of a way of how you would test that from a testing and certification perspective. So, we moved on.

Patient matching was also pointed out that folks on the Workgroup thought it was unnecessarily constrained with using month, day and year. So, those were the main points that we had captured so if there is anything else, again, feel free to add via e-mail.

Clinical information, reconciliation and incorporation, I don't recall any objections to shifting that and that I think folks thought that made sense from a workflow stand-point.

On data portability, we confirmed that the data elements hadn't changed and that I think the Workgroup had come to agreement on what it should be called. Now it was either going to be – I had down core clinical data migration but it may have been core data migration. So, if anybody knows for certain if that's not correct, you know, again let us know.

And then view, download, transmit to third-party also a robust discussion. I think I've got the two points here which were I think the main overall recommendations, particularly related to not requiring folks to have to send or receive from any Direct address where a trust relationship wasn't established and I believe that meant that certification shouldn't be requiring the establishment of these trust relationships.

So, that's what we were able to compile and put together in terms of a summary and I think we can move on at this point again I can't emphasize it enough, if you have any comments or questions, you know, via e-mail and we'll address those. Thanks.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thank you, and again, please send any comments so that we can get this clear, our goal from the Workgroup is to be able to present our findings on the 24th of April so we obviously need to get this information accurately reflecting our decisions. With that we're going to continue on with the review, which is the next slide.

Certification criteria that was scheduled for last meeting and Wes will take us through that discussion and the first one has to do with patient engagement, which is the next slide, please. Wes?

Wes Rishel – Independent Consultant

Yeah, thanks, so one more slide, please. So, the NPRM calls for updating the Consolidated CDA, we've already had, in the context of the clinical summary, we've already had this discussion in other contexts and we have raised some issues that Michael outlined with regard to this. I'm not sure that his summary actually captures the urgency of the concern and I'm going to comment on that by e-mail, I don't know that we need to revisit the issue here.

I think that the issue of CVX codes for immunizations is – I haven't heard anything of particular concern about that, but we may have others on the call, so let's just see if we have comments on that from anyone?

Okay, then moving on, I know from outside conversations that the plan to use LOINC for all diagnostic tests including pending and future scheduled requests has some concerns related to the specificity of LOINC and I'm honestly not sure what happens with regard to orderables as opposed to diagnostic tests.

So, there are things that are ordered that represent batteries or other ways of combining individual tests and I'm not sure whether this specification calls for using LOINC codes for those orderables. Does anyone else want to help to clarify that or have any specific comments about it?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Wes, this is Cris, I guess the question is, if, given that this applies, per the heading, only to the ambulatory setting does that in any way minimize the concern about the LOINC in coding issues?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, under this one it does, but I thought for the CDA that they also had to be backed up by the LOINC code. Mike can you comment on that please? This is Liz.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, I think anything in the CDA lab tests and results have to be coded in LOINC I'll verify that, but I'm fairly certain of that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And we are requiring the use of LOINC also in the exchange of lab data and those criteria as well.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right and the menu criteria, correct.

Wes Rishel – Independent Consultant

I think the most –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

This is David McCallie I joined late, at Wes's request.

Wes Rishel – Independent Consultant

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I have a comment.

Wes Rishel – Independent Consultant

Go ahead.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I think Wes your point about the mismatch of granularity between LOINC codes which are designed to describe things that have already been done and clinician orders which sometimes are less precise where in some cases the decision of what actually gets done may not be made until it actually happens would create problems where a future proposed order might not map to an existing LOINC code.

I think that would be a concern and the language of whenever we use the word "all" we've learned, I think, from mistakes made in Stage 2 that that's going to cause trouble because there is never a case where all will work. So, you need some language like "when available" or "if possible" or something like that.

Wes Rishel – Independent Consultant

Either that or – I'm going to suggest that we record David's comment per se, but add to that either some legal wording around "all" or a specific identified procedure for dealing with codes not be available and that procedure may already be in place for all I know, but there is always going to be the case that certain labs are doing procedures that have not yet made it into LOINC.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Wes Rishel – Independent Consultant

But, I think other –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

David?

Wes Rishel – Independent Consultant

Concern about the use of a LOINC code to identify a future order and I interpret future orders as being something that's in the plan basically. I think that is an important comment we need to highlight in our overall comments.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, this is Mike from ONC, because we didn't raise this issue, so I want to make sure I capture it –

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

We didn't raise this issue with the LOI for laboratory orders, which is a proposed –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Which also requires the use of LOINC for orders, for lab orders from the ambulatory setting.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, I want to make sure that folks are aware of that and I assume you want to apply that same comment to that criteria?

Wes Rishel – Independent Consultant

Well, I think, I think the level that we're expressing, based on our current understanding, is that this is a potential issue, I know that there may – well, I know that there may have been – there may have been some work done for orderable LOINC codes that are less specific and if so that may be the appropriate response from ONC with regard to the issue. But at this point I don't know and maybe I expect we'll hear from the labs and other places in their separate comments on the NPRM.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

But, Wes, this is Liz, I think what we're asking is would we want to make a general comment, that is in essence what you and David have both said, about the use of LOINC codes, because it's not –

Wes Rishel – Independent Consultant

Yeah –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

Yeah, so I think and I'm asking anyone on the committee who disagrees to say so, but I think we need to raise the comment –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Wes Rishel – Independent Consultant

That there is an issue about the specificity of LOINC codes versus the indefinite nature of future orders that needs to be resolved in the final rule.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And this is David again, I'm not exactly clear about what future scheduled tests means? If it's something that has been scheduled then, you know, it may be that it's fairly precise but there are sometimes plans to do something in the future that haven't actually managed to make –

Wes Rishel – Independent Consultant

Yeah, well, this is a clinical summary.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

This is a clinical summary which is a CDA document that I would expect often involved, you know, a plan in the sense of a clinical plan and that plan could include some diagnostic testing downstream.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, David, my – this is Liz, my understanding as well was that this is actually a named test, that this is not a nebulous sort of thing it's a named, you know, we're going to repeat "x" in one week.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah and my concern is that would still apply I think and I don't know how people are resolving this in the current world, but you can schedule for example a CT scan with or without contrast and the radiologist makes the decision at the time of the scan whether they need to do the contrast in which case it's a different code. I don't know if that's the kind of thing you could run into here, but it scares me when you say "all" tests must be coded with LOINC.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, yeah, I agree with "all" but I think even the example you gave we would provide both LOINC codes. I think you're absolutely right about "all." I think that that's a – and we should definitely make a comment on that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, this is Cris, can we just confirm, I'm wondering if the words "pending in future" are somehow red herrings pointing us at orders. I'm scanning here and I'm not sure that this is ever intended to represent orders. I think the intent is that this is that LOINC will be used on all diagnostic tests, well, period, but I'm sorry, I'm scanning the Regs trying to figure out if this really is intended to apply to orders or not does anyone know?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Mike do you know? I know this is the summary document, this is – eventually we recognize that they're going to want to obviously result back against these LOINC codes, but that is not in this edition that's in MU3.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But is there any controversy around LOINC on all results? I'm not sure there is. I'm hearing this conversation as being concerns about LOINC being used to represent the order and David's example of scan with and without contrast is as good as any.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, the order part would be, you know, so we didn't apply LOINC previously. So, there wasn't really an issue, but, you know, results were always like in the C-CDA LOINC results, you were supposed to use LOINC for results, for reporting.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Future scheduled tests is a CMS term for, you know, their summary of care record and we've taken that over so I suspect, I mean, I don't know how else you would interpret that, but I'm pretty sure that would fall under orders, right? So, I think that's – we don't talk about that, you know, that clarify that future scheduled tests –

Wes Rishel – Independent Consultant

Well, I –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Would be ordered, but –

Wes Rishel – Independent Consultant

The first question is what's in the C-CDA for the clinical summary section and what is in there with regards to orders that have not been resulted, okay, so they may have been placed and pending or they may be –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Oh, now I get it.

Wes Rishel – Independent Consultant

Planned all right –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Just planned.

Wes Rishel – Independent Consultant

And I think we have raised, at the level of detail that we're able to do in this group, we've raised a concern that it's not clear that LOINC can represent, in the context of the specific C-CDA sections, orders that have not completed the order cycle and been the general ordered term has been replaced with the specific plan. I'm not even sure how often that happens versus a coming back with the result.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, it doesn't happen as much –

Wes Rishel – Independent Consultant

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

You're right.

Wes Rishel – Independent Consultant

Yeah, right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

What happens is there is a care plan that might have it but it's not in the current summary, because that, I think is intended to be what happened not what's going to happen.

Wes Rishel – Independent Consultant

Of all the things – okay, so you're saying – I just think we need reference to –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

To the actual section of the CDA of the clinical summary profile for the C-CDA in order to understand exactly what's being asked, but we are in this – we are saying that we're going to forward to the overall committee a concern about the efficacy of LOINC in this and the committee will hopefully forward it onto –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And our concern is –

Wes Rishel – Independent Consultant

To ONC.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And our concern is with respect to orders.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And then we'll refer –

Wes Rishel – Independent Consultant

The concern is with respect to any description of a lab test that is not a result.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Correct.

Wes Rishel – Independent Consultant

You can get into distinctions –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Correct.

Wes Rishel – Independent Consultant

Between orders and plans –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Wes Rishel – Independent Consultant

And things like that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Correct.

Wes Rishel – Independent Consultant

But, anything that is not at least a tentative result.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Brilliant.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And the way this is worded, this is David, this says, all diagnostic tests, which I would include radiology, nuclear medicine –

Wes Rishel – Independent Consultant

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Stress tests –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Correct.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

For which there may not be LOINC codes for some of those.

Wes Rishel – Independent Consultant

Well, I think, LOINC has made a significant effort to cover all diagnostic tests, it's up to people who are commenting who have experience to say whether that effort has been effective or not. And I think we've already said that there needs to be something in the statement or in the document specifications that describes how to deal with a test for which there is no LOINC code and I think that's pretty well spelled out in the C-CDA data type actually.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Can we move then to new data element, you think you've got it, Wes?

Wes Rishel – Independent Consultant

Yes, I think we're – we want to see what – how Mike does the summary, but I think we've – I hope we've had – an opportunity to talk on these standards.

We discussed UDI in other context I don't see anything different here. I'll give the people in the group a chance to comment briefly and then move onto the next part of the document any comment?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike with ONC real quick –

Wes Rishel – Independent Consultant

Yes?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Wes, I just want to point out, so with the CDA, Consolidated CDA, right now the requirement is for tests coded to LOINC not the results, so just to make that clear, nothing is in the CDA requirement related to orders, whether an actual CDA can capture orders I don't know that answer I'm not familiar enough with the Consolidated CDA.

Wes Rishel – Independent Consultant

No question in my mind that the CDA can, it's the clinical summary profile –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, right.

Wes Rishel – Independent Consultant

That we're concerned about here. And I guess I'm actually having a hard time understanding what someone would write in a clinical summary –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

About an order or a –

Wes Rishel – Independent Consultant

About an order that wasn't –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

CQM –

Wes Rishel – Independent Consultant

I mean, there weren't results, you know, we find –

Joe Heyman, MD – Whittier IPA

They might put it in their plan and I don't know whether –

Wes Rishel – Independent Consultant

Well, that's right and that's why we want to – it clearly applies to the plan, but I assume that whether or not the lab results are one of those things that must be coded and decoded by the EHR, nonetheless, there is room for lab results in the clinical summary, it just wouldn't be much of a clinical summary if you couldn't say, well, we – you know, we found the patient has an ejection fraction of 50% or something.

Joe Heyman, MD – Whittier IPA

And actually for HIEs –

Wes Rishel – Independent Consultant

Yeah?

Joe Heyman, MD – Whittier IPA

A lot of places the only thing that they can send is a C-CDA, so it will be important to the HIE to be able to get lab results through the C-CDA if that's the only thing they can send.

Wes Rishel – Independent Consultant

Well, I think – so that's a comment, a separate comment that we should probably write down just exactly as Joe said it basically that the problem I think is not whether you can – whether you can put it in there, it's whether the receiving system must be able to decode it as structured data or not we know that it must, when it comes from a lab, what we're hearing, from Michael, is that there is no "must" when it comes through a clinical summary from another practice. And I actually don't know the rationale behind that, but I have a feeling it was done based on people in the S&I Framework finding difficulties in including it.

So, we record Joe's comment and then let's see if there are any other comments and then we'll move on. I think the comment itself or the importance of lab data being in the C-CDA because of the way HIEs work is definitely a first-class comment.

Hearing nothing else, we've talked about UDIs before. I don't see anything around clinical summary that makes the discussion different. So, I would ask does anyone see an issue that I'm not seeing and if not we'll move on.

Okay, now I read over the situational dependency of certain data and I didn't see anything that I wanted to comment on about it. Does anyone else have – I mean, Michael can you describe a little bit more about what that's about? It's been a while since I've read it.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, sure.

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, we just wanted to make clear that those – and I don't have the actual criterion in front of me, but that when you provided those set of, I think it's medications, immunizations, I think it's like the lab tests, that it would be limited to that – that your EHR technology, because this is for obviously testing and certification, would be able to limit that data to that visit and not provide just all the medications that that person has, you know, or all the immunizations.

Wes Rishel – Independent Consultant

Okay, so, it's related to what the clinical summary provides.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, right.

Wes Rishel – Independent Consultant

And it's emphasizing that it summarizes a visit as opposed to the patient status is that –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, I mean, like it just wants to emphasize that the EHR technology has to be able to limit that data to just that and not just provide a data dump so to speak in the clinical summary on those.

Wes Rishel – Independent Consultant

Okay, so the question is – I'm just trying to restate has to be able to in a little more precise terminology, the requirement is that it must limit the data in a clinical summary to a specific visit, is that correct?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Wes Rishel – Independent Consultant

Okay. Then we haven't really been discussing the gap certification –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

Ineligible issues. So, let's move onto the next slide.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay and Michael while you all are moving on, will you please include that so that when we do the write up on the situational dependency it would be much simpler if you would just simply say “limit data to single encounter” please.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Because, otherwise you read this and think “what?”

Wes Rishel – Independent Consultant

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, thanks.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

This is David, I have not unfortunately read this part of the details but is this requiring that it be limited to a single encounter or allowing that it be limited to a single encounter?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah and that’s what I want to go back and check.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Wes Rishel – Independent Consultant

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

We’ll make a note, thank you.

Wes Rishel – Independent Consultant

I –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

This is David, again, I would be concerned if it was required to be limited to a single encounter simply because it sometimes is very difficult to determine what an encounter is.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Agreed.

Wes Rishel – Independent Consultant

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Is a phone call an encounter for a follow-up of a lab test? It is in some systems, but that wouldn’t make any sense from a CDA point-of-view.

Wes Rishel – Independent Consultant

Yeah, so another possibility is that it's saying that in the certification testing the EHR will only be certified on including data that is provided under the guise of a specific encounter which if that's the interpretation I think it's one that vendors can handle okay, we just always have to be careful with the wording here because –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, the one thing I want to say is, because that's what, you know, the prior comment got me mixed up on was that what you can do and what you may have to do for MU is different than what the EHR technology is capable of doing and we do say that the EHR technology should be capable of limiting that information if the user so desires. So, I guess I am reiterating what I had said before –

Wes Rishel – Independent Consultant

Okay.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

It does have to limit it, it doesn't mean that you have to, as a user, limit it to just that data, it's just that if you wanted to the EHR –

Wes Rishel – Independent Consultant

All right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Should be able to use a specific date and capture just that data and provide just that data in the summary.

Wes Rishel – Independent Consultant

So, if we were to think out loud about what the certification requirement would be it would include the ability for the user to enter some option by which they say whether to limit the data in the clinical summary to data that is associated with the specific encounter that they're viewing at the time they ask for the clinical summary

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right –

Wes Rishel – Independent Consultant

And that there would be a test that includes data from multiple encounters and observes that the output product contains only data from one of the encounters. Is that a correct interpretation of what you're saying or is that a way that one could certify what you're saying?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I wouldn't disagree with that.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

So, this is David, I'll again, raise my concern that an encounter is a vague notion and I'm not sure if somebody is going to be picky on a test how they're going to decide what's in an encounter?

Wes Rishel – Independent Consultant

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Mike, has –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, I want to make sure I capture that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, because what we'll need to do before we actually present that back to standards is make sure that either Kevin or somebody else can't tell us that there is a definition. I agree with you, David, completely, we just need – you know, if there is a definition we need to see it.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And it's not clear to me exactly who is benefitting from this increased requirement, is this intended to benefit whom?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

The patient and that is coming from CMS and the CMS MU rule that this was always the intention that what's in the clinical summary should be limited to that office visit. If that's –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I see, so this is portal download capability, this isn't provider controlled, this is patient controlled.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, I don't want to get into like – I don't think there is any requirement on a provider to do exactly what the – I'm not going to speak for MU, I can't, but that's the idea that the patient should be able to get what comes out of that visit and they can ask their doctor, I just want – can you just give me a summary of what's in the visit and then the EHR technology should be capable of doing that and then the user could then limit it, user being the provider could then limit that information for the patient.

Wes Rishel – Independent Consultant

Well, okay, so this –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

The provider is not –

Wes Rishel – Independent Consultant

I didn't realize that we were only considering clinical summary in the context of view, download and transmit. So, I just want to confirm that this is the right context here that what we've been saying about the clinical summary relates to that as made available through view, download and transmit rather than – I mean, it doesn't even make sense to me.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I don't think it's limited. I mean, I don't – we have no limitation like that.

Wes Rishel – Independent Consultant

Okay, all right, now then the workflow that you described of the patients telling the physician what they want is almost never going to happen with view, download and transmit in my opinion. There is going to be an encounter, it's going to be in the electronic health record, the patient is going to go to the portal and they're going to ask to view, download or transmit that information.

There may be other scenarios such as the information is sent to an HIE or something like that, but just focusing on this, the question in my mind is, how does the EHR know what to do and frankly, as a background, I think the concern is that vendors have been interpreting clinical summary as a dump –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Wes Rishel – Independent Consultant

And I think that has limitations both in terms of the usefulness to the patient, but also in terms of the usefulness to another physician. Joe would you agree? You want to know what happened in that visit right not the entire history of the patient or am I wrong? Joe? I guess we lost Joe.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I mean, Wes, you know, as a former clinician –

Wes Rishel – Independent Consultant

Yes?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I'll say, you know, the answer is it depends, but frequently, yeah, the dumps are too long.

Wes Rishel – Independent Consultant

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And you know –

Joe Heyman, MD – Whittier IPA

I'm sorry, I missed that Wes?

Wes Rishel – Independent Consultant

Yeah, so Joe, we're discussing the benefits to the patient and to the receiving physician of this option to say that a clinical summary is not a complete summary of all the data about the patient it's specific to an encounter and we recognize that there are some definition issues around encounter and we're willing to finesse that for this discussion.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, I think CMS uses the term actually office visit.

Wes Rishel – Independent Consultant

Oh, office visit, okay.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And I would just give an example as to like a patient may say that to a provider, but what I think what CMS – you know, this criterion supports the CMS objective and measure which says, this is the information that has to be provided in an office visit –

Joe Heyman, MD – Whittier IPA

Right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And that's what should be provided. And the limitation, it's our understanding from CMS and I think it's actually in their rule that it should just be that information from what came from that office visit.

Wes Rishel – Independent Consultant

Okay, so with that –

Joe Heyman, MD – Whittier IPA

As opposed – what you're saying is from a single date rather than from multiple dates is that correct?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, so what I'm saying is the EHR technology should be able to distinguish the data for that patient and provide just what was, you know, either what immunizations were administered or what during that visit and provide that as a summary of the – you know, the clinical summary of the visit and not the clinical summary of every visit that patient has had with that doctor.

Wes Rishel – Independent Consultant

Yeah.

Joe Heyman, MD – Whittier IPA

Right, except the only thing I would add as a proviso there is that generally it includes the problem list and it includes a list of the medications they're taking isn't that part of the C-CDA?

Wes Rishel – Independent Consultant

Right.

Joe Heyman, MD – Whittier IPA

So, some of those things were entered at previous times but they're part of the C-CDA from that visit.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right and I think even CMS and we say that clinical summary can be customized by the provider. I mean, I don't want to beat, you know, a dead horse here, but all we're saying is the EHR technology has to have ability to limit some of this, you know, the information if so desired.

Wes Rishel – Independent Consultant

Okay, so as –

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Wes, this is Dave Kates.

Wes Rishel – Independent Consultant

Yeah?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Sort of along the lines of Dave McCallie's comment, I'll elaborate in an e-mail, but I think you get into some definitional challenges, for example, laboratory orders that are placed during today's visit but don't come back until the patient gets a draw and gets the results and how do you treat those. So, I'll elaborate on those, but I think again, getting a clear definition of encounter is going to be challenging and important.

Wes Rishel – Independent Consultant

Okay, so I think –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And this is David, you know, the other thing that happens is phone calls that occur between office visits but in fact refine change or modify what happened in the office visit, you know, good common sense knows exactly what you should include, but when you try to certify that and measure it as an encounter boundary you're going to have a hard time.

Wes Rishel – Independent Consultant

Yeah, well, I –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, we'll be waiting to get that more detailed information but I have down that, you know, how – the concern is over defining what constitutes the encounter and how that would be tested and then like actually even subsequent either discussions or meeting where you refine that information.

Wes Rishel – Independent Consultant

Okay, yeah, I'm going to suggest a potential interpretation here which is that first of all we are responding to an NPRM that is about what standards will be used and how an EHR will be tested for purposes of certification, we're not in this discussion or in our role on this committee responding to the NPRM on Meaningful Use.

Second, we understand that we don't always want to data dump, we want something restricted to an encounter, we understand that there are definitional issues around encounter, particularly when you think about these phone calls and subsequent lab results could come in after the clinical summary was generated, but the interpretation that we understand is that the EHR should be tested to show that in the face of it having data on more than one encounter that it could produce a clinical summary that only included one encounter and that's probably less controversial than the underlying definitional issue.

I think we also have to add the comment that we need the rule to be – the certification to be clear that the problem list, allergies and medications are aggregate or current or something like that as opposed to solely those identified or discussed in a specific encounter.

Joe Heyman, MD – Whittier IPA

This is Joe, I hate to confuse things even more, but could I just ask, is the definition of a clinical summary different from the definition of a C-CDA? In other words we're not talking about the same thing?

Wes Rishel – Independent Consultant

A clinical summary is a species of the genus C-CDA.

Joe Heyman, MD – Whittier IPA

That's what I'm asking, because for instance –

Wes Rishel – Independent Consultant

Yes.

Joe Heyman, MD – Whittier IPA

My EMR I produce a clinical summary that's much more robust than a C-CDA and it is of that date of encounter.

Wes Rishel – Independent Consultant

Well, we have to distinguish CCD and C-CDA.

Joe Heyman, MD – Whittier IPA

Right.

Wes Rishel – Independent Consultant

But, okay.

Joe Heyman, MD – Whittier IPA

But, what you're saying is that the clinical summary that isn't a CCD or a C-CDA does not count as the clinical summary.

Wes Rishel – Independent Consultant

All clinical summaries are C-CDAs.

Joe Heyman, MD – Whittier IPA

Okay, that's what I wanted to clarify.

Wes Rishel – Independent Consultant

But not all C-CDAs are clinical summaries.

Joe Heyman, MD – Whittier IPA

Okay, all righty.

Wes Rishel – Independent Consultant

Okay, so we've given Michael a challenge to capture this and we'll be testing him.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, I know, I'm sure I missed some.

Wes Rishel – Independent Consultant

His orals will occur during the next call.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, the one thing I do want to point out before we move on –

Wes Rishel – Independent Consultant

Yeah?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is a clarification for also the 2014 edition.

Wes Rishel – Independent Consultant

Right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Just so we know that, okay. So, it's not just –

Wes Rishel – Independent Consultant

Yeah, okay.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

You can still, but I just want to make that clear –

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

It's not just part of a proposed criterion.

Wes Rishel – Independent Consultant

Right, okay, so I am thinking that I don't see any reason why that would alter our discussion.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

No, it wouldn't, I just wanted to –

Wes Rishel – Independent Consultant

All right, yeah, okay.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I just wanted to make that –

Wes Rishel – Independent Consultant

Yeah, no, I appreciate that I think it's important for us to be aware. Okay, if we could advance one more slide, please. All right, so in the previous call we discussed the general, I'm going to call it a theme for lack of a precise term, that works throughout the 2015 edition NPRM which is to separate standards for content from standards of method of delivery in effect creating a more universal approach, there are various kinds of content that are required in different scenarios and they can be delivered through any of – they must be delivered through all of the transmit and transport standards here rather than this one must go by Direct and that one must go by something else and the only exception is that the applicability statement for secure to health transport and delivery notification is specifically called out as a requirement for labs, because of CLIA, CLIA confirmation requirements.

But, nonetheless the way I understand the structure, if somebody wanted to use delivery notification for a transition of care the certification would test that happening, I mean, first of all I think the first comment we have here is that the certification – well, I guess it's more of a question, does that mean that the certification now requires testing every possible delivery document against all possible transmit/transport standards?

So, if you've got 5 different types of documents, lab orders, transitions of care documents, clinical summaries does the certifying body have to test each of those, I gave three, against each of four transmission methods?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Michael I'm guessing that's a question for you or I think?

Wes Rishel – Independent Consultant

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Wes Rishel – Independent Consultant

For Michael, yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Oh, okay, so I'm – this is somewhat – sometimes I'm out of my realm.

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, as I understand it, yes, you know, the delivery with Direct notification would let you know if the message got there, so I think it's the whole message is my understanding.

Wes Rishel – Independent Consultant

Right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And, yes, it would be something that would be valuable for any provider not just labs, you know, sending lab results back. The question you're asking seems to be like would they parse out the message as to what was received?

Wes Rishel – Independent Consultant

No, I think, we understand that –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Wes Rishel – Independent Consultant

That the principle is independence of transmission method from content.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Wes Rishel – Independent Consultant

So, that leads to a question of are we testing the transmission methods and testing the contents or are we testing the independence.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, I don't –

Wes Rishel – Independent Consultant

If –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, yeah, I don't know the answer. I don't think we even talk about how we would test it –

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

In the rule.

Wes Rishel – Independent Consultant

Okay, I have to admit I'm of two minds about this, I think pragmatically when you start to multiply things together in terms of a certification criteria that is sort of limited by the amount of budget that you want to charge vendors for testing, multiplication is a bad thing. So, I'm thinking that it would be adequate just to testify, to certify each of the documents and some document in each of the transport mechanism but not each document in every transport mechanism.

In terms of translating that to a comment, I guess it would be we would want to know, in the final rule or in – I guess there's an issue around certification approach that it doesn't – that some of that comes subsequent to the final rule, right, in other statements about certification criteria.

So, fumbling around here, I think the comment is we're concerned that testing of every document to format against every transport standard would be an excessive testing burden. Now, I've kind of vaguely got to that result thinking out loud, I want to give other people a chance to disagree with me.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Wes, this is Cris, I think that's right as a principle for all the reasons you said, I think there are – I would have different views depending on what the answer was to another question, which is I think there are other issues lurking in here other than just the separation and the content and the document. It's also the decoupling with respect to the activity of transition of care and view, download and transmit, which was this idea related to Direct edge protocols separate from HIE protocols.

And as I understand it at least part of the purpose of this regulation is to separate out the HIE activities from the document creation and management and content topics so that an EHR vendor does not need to – so that we can adequately test EHR vendors where they supply transport and where they don't supply transport.

Now our colleague, David McCallie is either going to agree with me or tell me I'm completely out to lunch, but I think that piece is in here too, so I think that effects how I think we should think about your proposed formulation. So, I don't want to go off your topic, but I'm not sure we can completely address your topic without identifying all the layered issues that are in here.

So, can I put McCallie on the spot, David, am I anywhere close to right about this issue about decoupling the HIE and the EHR activities with respect to transport?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I think you are Cris, I will admit to being very confused about the linking of that decoupling to the edge debate, but they have in fact linked it and I think –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Your formulation is right is that some EHRs have implemented the generation of the content so tightly woven into their connection to Direct that you couldn't separate those two if you wanted to switch to a different Direct vendor or something.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And they're asking for that separation.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah, and –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So –

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Cris, its David Kates, and I know from our firm's perspective and, you know, some of our health system members it's that like a specific use case being whether some of the responsibilities for view, download and transfer of – for patients to be able to view, download and transfer their clinical summary that they could essentially delegate that to the HIE or something like that.

So, some of those functions that there is a little confusion in the marketplace right now, this tries to separate those so that they can certify the HIE to do certain aspects of that on behalf of –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's exactly my understanding too and I'll admit that I've read more of the commentary than the actual rule itself, which is both good and bad, and my understanding matches David Kate's as well as David McCallie's is that the intent here is to decouple this from the stand-point that we want to be able to create these documents without thinking about transport standards.

So, in Wes's formulation that would say "for God's sake don't test the combination of document and transport." I think there's a separate issue which says "we're not going to ask the EHRs to test as if they are an HIE" and that there's going to be a separation around a distinction about what happens in the so called, edge protocols, the HISP to HISP protocols separate –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, that's what I was going to ask you –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

From EHR to the HISP.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, so as you guys have sort of laid out this roadmap that makes sense from a user of the functionality does that mean then the provider, let's say – is the essence of this that as a provider I need to find a product that is certified for content and maybe the same and maybe a different product that's certified for transport and assume they will work together?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think that's right and I think it is that the certification is intended to be, can you produce the document as required –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And does your product support one of the transport methods that's listed in the specification.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But, it doesn't require that one certify against all those things simultaneously.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, again –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I just want to ask one more time, so what you're saying is that – and we'll pick on David for a minute, so if Cerner would say, one we certified in content and by the way we're going to use Direct or we're going to use – correct?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

So –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, exchanges –

Wes Rishel – Independent Consultant

Okay so what I –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

David –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

It raises the interesting – this is David, it raises the interesting question of how does one certify – how does one get – how does the certifier get his hands on the content to certify it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, exactly.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Where today you send it over Direct or you download it to the view, download, transmit. I'm not sure what the requirement would be to externalize the content, the CDA outside of one of these modes of transport for certification purposes, they'll have to specify a test rig of some kind.

Wes Rishel – Independent Consultant

Okay, so I think, we agree that we understand the concept is that the content of reports and sort of related business issues are tested using – are tested independently using some method for accessing the data, but there is no correlation between the scenario, the transition of care or VDT, or the document type, clinical summary or other document type and a specific means of transmitting, and we support that approach in the NPRM. So far so good?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So far so good.

Wes Rishel – Independent Consultant

Okay, I think, we understand that and here's where I'm proposing throwing something out on the table to – throwing a red herring on the table to watch it flop, we understand that the certified EHR should be tested for transmitting some document on all four of these methods of transmission, 170.315 (h)(1) through (h)(4) so that in order to be successfully certified an EHR has to be able to do all of those. Is that the intent of the document and if so do we support that intent?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well –

Wes Rishel – Independent Consultant

I'm going to argue we should.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike with ONC –

Wes Rishel – Independent Consultant

Yeah, go ahead.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, my understanding, and like I said this is not my area of expertise, is that if you were certified, your EHR was certified for transitions of care the extent that it would go to would be the certification to the edge protocol not to any of these particular transmit standards.

Wes Rishel – Independent Consultant

Okay, well, so –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Now if you were a provider you would still have to have something or use something that was certified at least to Direct because that's part of the base definition. You would at least have to have it, you wouldn't necessarily have to use Direct you could use one of these other transport methods, but that was just –

Wes Rishel – Independent Consultant

Okay, so we have four –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Does that make sense?

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

More sense?

Wes Rishel – Independent Consultant

Because we have four flavors of Direct listed in (h)(1) through (h)(4) and because it's Direct we have the issue that none of these really describes the edge protocol between the EHR and the HISP. All of these (h)(1) through (h)(4) are statements about how HISPs interconnect. Is that correct David? No, yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

No, I mean, well they've bundled the thing as a whole up until now.

Wes Rishel – Independent Consultant

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And they're to tease it apart.

Wes Rishel – Independent Consultant

Right, right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

So, these – you know, they bundled, for Direct anyway, they've bundled the entire process from EHR through the HISP –

Wes Rishel – Independent Consultant

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Across the network through the other HISP down to the EHR as a single thing and so part of their decoupling is to tease apart that. The other part of the decoupling, completely orthogonal, is content from transport.

Wes Rishel – Independent Consultant

Right.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And it's horribly written because it mixes those two senses of decoupling, but that's what they're trying to do is both senses.

Wes Rishel – Independent Consultant

Yeah, okay, so in previous –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

And I think it's a good idea, I'm not sure the suggested implementation of all four edge protocols makes any sense, but the decoupling idea is good.

Wes Rishel – Independent Consultant

Well, I guess, what's an edge protocol, the edge protocol is the protocol between the EHR and the HISP is that right?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Correct.

Wes Rishel – Independent Consultant

Okay, are any of these edge protocols?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Of that 1 through 4?

Wes Rishel – Independent Consultant

Yeah.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

No.

Wes Rishel – Independent Consultant

Okay.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Well, no, although some people are using the XDM, so called Karen's Cross, the XDM as a de facto edge protocol.

Wes Rishel – Independent Consultant

Yeah, all right, okay.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

But it's not called that specifically.

Wes Rishel – Independent Consultant

Right, all right, so the – we have previously commented that we thought that any requirement to test a standard edge protocol was premature for 2015 and I think in regards to this portion of the standard, of the regulation, which is 170.315 we don't read, and Michael tell us if – we don't read the specification, the NPRM as requiring that the EHR be tested to (h)(1) and (h)(4) is that correct, they're not required to be tested?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

They're not required – well, I mean, you're – an EHR can get certified to anything that it wants to.

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, you know, that's the general rubric, but like for transitions of care no it's not required to be tested that's the decoupling.

Wes Rishel – Independent Consultant

Well, no we're trying to separate –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Wes Rishel – Independent Consultant

We're trying to separate –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, and HIE let's say could come in and get certified to any of these transport standards and that's it and it wouldn't be certified to even the edge protocol it would just be certified to be able to send in that using Direct.

Wes Rishel – Independent Consultant

Yeah, okay, a new category of vendor that's – well, it would be the module EHR?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, it would be an EHR module, right.

Wes Rishel – Independent Consultant

All right, okay. So, we know that of these 1 through 4, 1 through 3 are already in the 2014 edition.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Wes Rishel – Independent Consultant

And, okay, so I'm now looking at the third bullet.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah.

Wes Rishel – Independent Consultant

Under transport standards decoupled.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

That's an important point.

Wes Rishel – Independent Consultant

All right. All right, so we concur with that. I guess I'm bound to – I've corrected some misunderstandings I had about this section as a result of the discussion.

What we understand is that basically the EHRs, the modules of EHRs that produce information for ToC and VDT will be tested using some method of getting that block of data that represents the formatted healthcare information, that they – so I guess the question is, are they certified for Direct at all and if so are they certified by using – right now I think in 2014 they can use any HISP, right, in order to get certified? They can be their own, they can use a third-party, but they have to somehow demonstrate –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

They have to exchange with each other.

Wes Rishel – Independent Consultant

They have to somehow demonstrate actually sending by Direct, okay.

Now is that the plan for the 2015 edition that they have to certify some method of being sent by Direct, because we don't think there is an edge protocol specification ready for the 2015 edition?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, so for – your question was does who have to get certified?

Wes Rishel – Independent Consultant

An EHR vendor.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, okay.

Wes Rishel – Independent Consultant

Who is, you know, we used to say a complete EHR –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Wes Rishel – Independent Consultant

But and I'm trying to approximate that notion by saying, who is able to create the content, the formatted health information required for transitions of care or view, download, transmit.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, no, they do not have to get certified to any transport standard if they didn't want to, just the edge protocol and I mean, I've heard the – your comments and concerns about the edge protocol but I think, you know, I guess maybe for me because I'm more layman in terms of this, to break it down in simplest terms it was to make that EHR be capable of transmitting with Direct that then an HIE could get certified to, you know, (h)(1) and then the assumption being that this HIE would be able to work with the edge protocol and then they could exchange versus today, like you said, an EHR vendor either incorporates it all into their product or works with a HISP to do it together.

Wes Rishel – Independent Consultant

All right, so I'm now realizing that the third sub-bullet is talking about receiving rather than transmitting.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right and so –

Wes Rishel – Independent Consultant

Okay.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, so sometimes a vendor could get certified to (h)(1) as well and so we didn't want to put that into the requirements here because then there would be some redundancy in testing. So, that was one of the reasons why it would require an edge protocol.

Wes Rishel – Independent Consultant

Okay, well, there's obviously two issues. Boy this is complicated. There is one issue about being able to send a standard artifact using a standard method and there are others about being able to receive and decode information from a standard artifact using one of the standard methods.

And so what I think I understand is that under the 2015 edition the proposal, the NPRM, is that there is a standard edge protocol for sending data but that same protocol would not be tested for receiving data.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Wes, this is –

Wes Rishel – Independent Consultant

And we have had our comments about the readiness of the edge protocol standard.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Wes, would it be easier, I mean, this has been I think very enlightening for all of us –

Wes Rishel – Independent Consultant

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Do you think it would be easier if we stopped on this topic, got Michael to kind of reiterate in a written format which would allow for comment what we have determined and get confirmation of it and then finish it?

Wes Rishel – Independent Consultant

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Wes Rishel – Independent Consultant

I think that would be great and what we might ask to do is the have ONC make available the people who are closest to this for some further discussion about it.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And along those lines please send me your comments and questions too.

Wes Rishel – Independent Consultant

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, that way I can like kind of reconcile them all together.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right and then what we can do on the next meeting, because this has been very, very helpful and I think a lot of discovery, but that way we can make sure that what we – we understand what we're commenting on and that our comments reflect on what it is we were supposed to comment on and we can move on to the next one.

Wes Rishel – Independent Consultant

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, great.

Wes Rishel – Independent Consultant

Okay, so, I'm going to suggest that approach applies to the rest of this slide, we've already talked about (h)(4) –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Wes Rishel – Independent Consultant

(h)(1) being a part of the base EHR definition is – I don't know that it has – I don't know how to interpret it, we're not going to talk about gap certification. So, at that point I can give up the helm here.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thank you, Wes, I mean, it's a really tough subject and I think – I know I learned a lot and I'm sure everybody else did as well and now we just have to get it documented so we can make sure we're on the same page. With that, we have about 17 minutes left can we move on you think fairly quickly Mike through this other –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, I think I can get through my two, I mean, I have to give you guys your opportunity, but I think they're pretty simple in terms of what we're proposing for the next two.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

We'll –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And actually for electronic notes when we get to it, I would ask folks to just submit their comments on the quote, because we ask a few questions there and there is no point to go through every question, but anyhow let's move onto those and see how far we can get. Does that make sense?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Perfect.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, so next, I think we need to go two slides, okay, so electronic notes. So, previously we initially proposed to require to search across notes and then we pulled back and just said, search within a note, well now we're going back and proposing that again. And we just essentially ask for feedback and questions and you can see the listed ones here.

I don't know if there is any – I mean, we can spend some time here on it if you want, but, you know, there are four specific questions in which we ask, you know, how that functionality should be implemented and, you know, whether we should do it now or wait, we definitely are curious as to whether providers have that functionality already and/or think it's a necessary functionality.

MU doesn't require this right now, but – and then, you know, whether how far we go into metadata related to the notes was another one.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, let me ask a question of the Workgroup, given our time and given that we probably would like to comment on these, would everybody be acceptable to taking a homework assignment and you can answer all four or just one of the question but please send us the answers so we can accumulate them and we would not aggregate them meaning we will not take people's comments and assume that it's the same thing, Liz and Wes said the same thing, we will actually give them back to you, but that way we can get through this, because I think that our ability to comment is important.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right and we can make it part of the summary at the next meeting.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, does anyone object to that?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

So, you –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

It sounds right, Liz.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

You want us to – just if we have thoughts about this you want us to send them to you in writing, is that what you said?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Correct, that's exactly right, to Cris and Mike, and Michelle and I, please, that would be terrific and then we can move onto the next one.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Any comment, I think without answering the question, the questions I think will answer the requirement question that would be my sense.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Joe Heyman, MD – Whittier IPA

And we have that slide, right, at home? I mean, you sent it out with the –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, it should be – it was sent out to every member of the Workgroup, so yes.

Joe Heyman, MD – Whittier IPA

Okay, no sweat.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Great, thank you. All right, move onto –

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

This is John Derr.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Go ahead?

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

Just one thing, on gap certification –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

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

You have ineligible, you want someone like me to comment on these things for the ineligible people or what does that mean?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

That's –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

No, gap certification just means you can't use the prior test results to get certified to this criterion, so if you were certified, if you're a vendor and your EHR technology was certified to the electronic notes for 2014 edition, if we adopted this 2015 edition version as we're proposing it, you wouldn't be able to use your test results from the 2014 to get certified to this one.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, John –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And that's simply because we're adding a new requirement.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And so you wouldn't have that, we wouldn't know you had that capability based on prior testing.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, that's a good catch.

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

Gotcha.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Got it, thank you. Family history.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes, so this one is a pretty quick one too but we can take comment now on it because it's just really one, if we can move to the next slide.

Okay, so all we did here is essentially what we forecasted in the 2014 edition which was move to just HL7 pedigree and that's because now there is an implementation guide available. So, that's it and so I guess we can take comment as to whether, you know, that's a good idea and not be able to allow SNOWMED anymore or whether, you know, folks think that we shouldn't move to just – for various reasons, whether you don't think the implementation guide is good enough or do you think SNOMED is still, you know, viable.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, can I ask a question, I understand that the standard is now available, but how widely is it being used? So, in other words is this something every one of our vendors would have to now incorporate and would be invisible to the end-user? David, do you know?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You sound like Dixie Baker.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I know.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's good that was a compliment.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thank you.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I think it's pretty new, so there would be vendor work required, the other comment I'll make while I've got the floor is that if ONC makes the change and disallows things that they previously required when they set the incentive criteria, I know that's not ONC's side of the equation, but, you've got to account for the fact that you changed the rules of the game and try to avoid forcing mass conversion of stuff that was at one point acceptable and is no longer acceptable like we've run into with the problem list.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right and the other thing that it creates for us is if someone, say Cerner, decides to do this certification then we're going to be caught half way in the middle.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, yeah, not to mention that problem.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, meaning that we're going to be –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

But the one thing –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Trying to certify on 2014 when we're trying to test out 2015.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

And, yeah, I think we want that feedback, so I would want to know like how long something like – ONC would want to know like how long something like a switch over would take, because as you know this is a voluntary edition.

So let's assume, you know, not – it's just an assumption that if we were to propose this in the 2017 – like you would have heard about it here, what if it became a requirement in 2017, if you're making the assumption that we're building on these, you know, editions, is that not enough time?

I think that's a – I'm hearing concerns and so I just want to make sure we get all the concerns in terms of like timing and all that.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, this is a complicated set of changes so the more time –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Is better, no question about it. This effects user interface, it effects existing tools that are already capturing in a Non-HL7 fashion that would have to be converted, this is a lot of work.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, yeah, if you have any more related to that, I've captured that, but if you have any more specifics or anything that would be very helpful and also you can submit comments separately or as part of the Workgroup, but –

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I'll ask.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

All that's – I think, I'm going to turn it over now to my colleague Lauren Wu who worked with CDC in some of our proposals related to all the public health certification criteria.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Okay, thanks, Mike, I think we need to leave a little bit of time at the end for public comment, so we might be able to just do the first public health objective. All right, next slide.

All right, so this one is about immunization information submitting that information to the public health agency. There is an update to the implementation guide, the HL7 2.5.1 implementation guide, we adopted Release 1.4 in the 2014 edition and CDC has recently issued Release 1.5.

From what we understand, Release 1.5 is not a big change from Release 1.4, it really just does a few things, it clarifies a few statements and it corrects some acknowledgement message guidance and there are a few query and response changes, but those are the three things that we understand have changed and other than that the guide has not changed. So, we proposed to adopt that updated implementation guide.

So, I go through the other items on the slide or do you want to stop and discuss that, that first point?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I think we should discuss since again we're updating the immunization guide much less talking about bi-directional, I can hardly wait to get to that one. David is this essentially the same issue where – and it may not be, but early or no adoption of a new standard and having to make a – I suspect this change will be required in 2017, but that's a lot later than now.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, yeah –

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Well, you know, I think it's a good question and a good point, you know, this update doesn't move toward full bi-directional immunization exchange it gets the community a little bit closer and the community, as I understand, is working toward full bi-directional immunization implementation guide, which, you know, we don't know if it will be ready in time for the next certification edition or not, but that is the direction that they are moving toward.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Cris, did you have something?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, I was going to comment, I think, that there is not, correct me if I'm wrong folks from ONC, but I don't think that there is any particular controversy around this Version 1.5. I think it's seen as a set of technical specification improvements that are well understood.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think there are some other issues coming up here around policy issues, but I don't think there is any controversy around the implementation guide within stakeholder groups.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Yeah, yeah, I would agree with Cris, from what I understand, you know, we've learned a few things about Version 1.4 where some states are doing things in varied ways that may limit interoperability. So really the changes made in this updated guide are to kind of cut back on that and promote interoperability on a small scale level.

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

This is John Derr, just one point, you know, we with 1.6 million people in skilled nursing homes, we do a lot of immunizations and are we included in this guide?

Because, I know at one point I got involved with this and there was no – nobody collected the data that we do, we do a lot of immunizations, especially for people who are dual eligible. Does the guide include us?

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Do you mean does it – can it be used for other settings Non-MU settings?

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

Correct.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Yeah, I think that's a question for CDC, but I don't see – it's not, as far as I know, limited to MU eligible only.

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

Okay, I just wonder whether I should start to do some work on this if it doesn't – never mind, I'm –

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Well, I think this is, you know, the direction that the community is moving toward. So, you know, I know we've been talking about voluntary certification of other settings and so, you know, moving – if we want to move everyone in the same direction it probably would be of interest for your community to look at.

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

Will do.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, are we hearing as a group that we think the updated implementation guide is a good idea or are we not ready to commit at that level?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Liz, the people that I know that are working on this would suggest this is a set of technical improvements that are non-controversial.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's one viewpoint –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But I think it's relatively well informed.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Anyone feel differently and that's – and hopefully, Mike, you caught that or somebody did, that's a great statement.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, I've got that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great, anybody feel any differently?

Wes Rishel – Independent Consultant

This is Wes, I just have a question, what's going on to make the states do a synchronized change here?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, that's the issue that I wanted to raise and we're going to run out of time today is –

Wes Rishel – Independent Consultant

Okay, all right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You know the Meaningful Use – the recommendation for the 2017 edition is to remove some of these requirements and I think there is some concern about that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, so should we put that on next time?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think we – I would suggest that we stop and go to public comment and that we come back and start with these, the public health, these four registry items quickly. I can volunteer to be the Wes Rishel for that section to start us off the next time around if that would be helpful.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, yeah, and would we, again, re-invite the folks from ONC as well to help you?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Of course, of course, of course.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great. So, Michelle, can we go to public comment?

Public Comment

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

Operator could you please open the lines?

Rebecca Armendariz – Project Coordinator – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Liz, this is Cris, I wonder if we just can do a little bit of housekeeping here in that 2 or 3 minutes that we've got.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Absolutely.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Does ONC want to lead with some of that it sounds like you've got some ideas?

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Sure, so, yeah, I mean, I thought we'd get farther, personally I thought we'd get farther today and that's my own mistake I think on that in terms of some of the issues I think I didn't – you know with the public health especially to think about.

So, we have a lot next call and I'm not – we made need to maybe institute a timeframe for each topic now, might be a way to make sure we can stay on schedule, if that makes sense?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I would suggest –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Like –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I would suggest we have a timeframe, but I think some of these items are express items and some of them aren't and so we should take that into account, we should, you know, give some of them 5 minutes and some of them 10 or whatever it might be would be my suggestion. I guess another suggestion –

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Yeah, I –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Is I feel like we wander around or we lose time when we are trying to do discovery so there is a lot of richness to some of the topics we talked about today. If there is a way to have a better or deeper summary of issues ahead of time that obviously would help if there is a way we can get enough staff support or volunteer support to do that. That would be my additional suggestion for speed.

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

I think, the only concern has been that we haven't really had the volunteers to do the work.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Amen, I understand.

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

So, I mean –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, I'll volunteer to do the public health ones.

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

Okay, so that's great, I mean, if we can get the comment beforehand then we're able to flush it out a little bit more and provide feedback and, you know, compare things –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

So it's much easier to react to something than to have a discussion on the call.

Wes Rishel – Independent Consultant

Well, I don't know, I think it's a volunteer issue, but if we simply had the language of the actual proposed regulation and the main commentary organized by topic here –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well –

Wes Rishel – Independent Consultant

And at least some of the more arcane cross references explained that would be a huge amount of help.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, I mean, Wes, it's tough to get all that on slides, you can see that we have 16 slides right now –

Wes Rishel – Independent Consultant

Yeah, no I don't think you could put it on slides, you'd almost have to –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Wes Rishel – Independent Consultant

Distribute it as a handout along with the –

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Which is what the rule – you know, we hope that folks would have time to look at the rule. I mean, what we tried to pull out is all – what we actually proposed and what the – you know, as specific as we could without, you know, filling up a whole slide what the rationale was for that change in terms of like, you know, some of these particular criterion are more than a slide like view and download, and ToC they would be two slides just themselves and then all the references to all the different standards would be more slides.

So, it's just – I think it is some of that ahead of time, like if somebody is willing to volunteer we're willing, staff is willing to talk with them about clarifications ahead of time if need be.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Yeah and this is Lauren, I was going to suggest, Cris, since you volunteered to lead the public health discussion, we're happy to have a pre-call and maybe if there are some questions, clarification questions you have ahead of time we can get those, run them by our public health experts here at ONC and then have those ready for you so that we can cut out that discovery time.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, if you could just contact me by e-mail off line let's set up a discussion for next week before our next meeting, I would love to have exactly what you said.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Okay, I will do that Cris.

Mike Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Because that's part of it too is while we know the general proposals and the rationale we do have experts in different areas that can help out when needed.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great.

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

So, I think that we should follow-up with the group via e-mail and just remember we're still on the public line, so, I think that we probably should close this line out.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, well, I think, Cris, I don't – I think we've made great progress as always and we are all going to meet again on the 23rd and or the 17th excuse me and between Cris and myself we will make sure that one or the other owns all of these criteria and that we get information out in advance so that we can get ready on the 23rd, which is the day before we present, to really kind of come to some final conclusions. Fair enough?

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

All right, thank you, Liz.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thanks, Cris, thanks to all the members.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thank you.

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

Thank you, Wes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thank you, Wes, bye now.

Joe Heyman, MD – Whittier IPA

Bye everybody.

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

Bye.