

**HIT Standards Committee  
Implementation Workgroup  
Transcript  
April 17, 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 call 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**

I'm 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**

I'm here.

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

Hi Cris. Anne Castro?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I'm here.

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

Hi Anne. 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 Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Here.

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

Hi John. 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**

Hi John. Joe Heyman?

**Joe Heyman, MD – Whittier IPA**

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? Is Mike Lipinski from ONC?

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

Yes, good afternoon it's Mike.

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

Hi Mike. Lauren Wu?

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

I'm here.

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

And Kim Wilson?

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

Here.

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

Is anyone else on from ONC?

**Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator for Health Information Technology**

Scott Purnell-Saunders.

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

Hi Scott, sorry Scott, I forgot about 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**

Thank you.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

Mike Lincoln is here I couldn't unmute quick enough.

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

Thank you Mike.

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

Okay, great. Hello everybody and thank you so much to those who are continuously faithful in getting this work done. We have quite an agenda today so we're going to be very directive and moving through the materials because we want to be ready next week, on Wednesday, to present the Workgroup findings to the Standards Committee. Can you move to the next slide please?

So, you can see on March 13<sup>th</sup> and then 21<sup>st</sup> we moved through the items on the work plan as planned. Next slide, please. And then last time we did make significant progress very difficult topics to explore but we got through those and today we will continue on with the remaining items from the 4<sup>th</sup> and get through the 17<sup>th</sup>.

I'm very pleased to say that Cris will be leading us through the public health certification criteria followed by John through the remaining criteria and again I want to be sure that we're real clear with everybody we absolutely want your comments, but if we see the conversation getting into one that has great benefit to us in terms of documenting and getting those comments into the final comments of the Workgroup but we've appropriately covered the topic for the Workgroup session today we're going to ask you to submit those comments in writing and they will be included.

I'll remind everybody that our job here is not necessarily to come to a consensus that divergent opinions are not only welcomed but encouraged so that we can give full picture and also to remind you that a number of us sit on the Standards Committee and can add comments at that time as well as there is always a public comment.

So, I just want to be sure that we capture all comments as appropriate and absolutely encourage not only that those come today, come through e-mail and then can be also included at the Standards Committee. With that and really being again very cognizant of time I'd like to turn it over to our Co-Chair, Mr. Ross, and he's going to go through public health certification.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I think we want to go to slide number 8 in the deck and I'm going to be jumping back and forth between slides so we're in the right place. So, I'm going to try to summarize these issues as clearly as I can from comments from staff and see if there are objections to these conclusions I think that's probably the best approach.

So, I'm starting with immunization registries and the comments I think or the perspective is this, the big issue that we're facing is bidirectional exchange for immunization registries, it's easy to submit an immunization to a registry the question is how do you query a registry and find out did Jane Doe have this particular set of immunizations.

There are currently six states they're all doing it different ways and the goal of this implementation guide release 1.5 is to remove those state and jurisdictional differences. So, to a large degree this is simply technical improvement to support unification between those six states so that it could be extended elsewhere.

So, just very quickly, the 2015 directions are only about the implementation guide. There is a reference – hang on just let me look through my notes for a second – so the question was whether the standards should be HL7 2.5.1 which has been the standard or something else.

And so the implementation guide writes those measures so that it could be accomplished in multiple ways. So, in order to accomplish the history through a bidirectional method the 2.5.1 HL7 standard may not be sufficient.

So, it has been previously reviewed at the Health IT Standards Committee with the belief that this guide is going to be sufficient, so this is mostly an effect on the registries as opposed to an effect on EHR vendors, their standard would stay the same.

And then there has been – so that's the primary issue is around the implementation guide. The secondary issue is around this issue of CVX code versus NDC and we have a little bit of disagreement between communities on this.

The CDC likes the NDC codes, ONC on the other hand would like to have us move to RxNorm, which has been the standard for other prescription management. So, on this particular issue there is a question about CVX versus NDC vocabulary and frankly the recommendation from ONC previously has been around RxNorm.

So, I think there are two questions here, number one do we want to make any commentary whatsoever on the implementation guide as issued by CDC, again, this is a technical improvement to codify what's already happening in six states and I think from most perceptions is not particularly controversial and then we can talk about the issue of CVX and NDC. So, are there any comments on the implementation guide?

Hearing none, and I think the question really is around the recommendation of CVX versus NDC. CVX is a set of vocabularies that are specific to immunization but the general direction that we have employed in other standards has been RxNorm which aligns with NDC.

**David Kates – Senior Vice President, Clinical Strategy – NaviNet**

So, this is Dave Kates, I can't speak to the CVX standard, but I think we certainly want to recommend consistency in terms of drug related terminologies and align with RxNorm and I think we all know, but the challenge with NDC is the granularity, Cris you know this in spades.

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

Right.

**David Kates – Senior Vice President, Clinical Strategy – NaviNet**

You know, the granularity of NDC codes which is not consistent with medical practice it's more a manufacturing code and therefore we want to up level it to something that's more clinical and appropriate.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right, right.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

This is Mike Lincoln from VA, we have a lot of experience with CVX and RxNorm and NDC as part of our NDF-RT Project that we work with NLM on. NDCs are definitely inappropriate. We're currently in our DoD to VA interoperability approaches using CVX that's our designated standard. We're using RxNorm for all other clinical drugs but in addition to RxNorm we use CVX for vaccine interoperability exchanges.

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

And so is that because it's not manufacturer specific? I mean, in trying to get to the simplest term?

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

Yeah, NDC codes, if you have – if you've worked with those very much they're very package specific.

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

Right, right.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

And manufacturers come out with different packages all the time and most of the packaging details are irrelevant. So, CVX just like RxNorm kind of neglects the package details to try to identify the "clinical drug."

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

So, Cris, would we maybe give the benefit of each, the similarity and familiarity with RxNorm and the benefit of the CVX codes and put it to the Standards Committee?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So –

**Wes Rishel – Independent Consultant**

This is Wes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes, Wes?

**Wes Rishel – Independent Consultant**

Hey, I may have managed to get myself confused here, but the question – is the question NDC versus CVX or RxNorm versus CVX?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

The question is CVX versus NDC I'm sorry I should have been clearer.

**Wes Rishel – Independent Consultant**

Oh, okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But NDC is within a family that's migrating to RxNorm so the point was that in other regards the recommendation is RxNorm of which the precursor is NDC. So, if we felt strongly about RxNorm there would be an argument to say go down the branch that's NDC to RxNorm but I think we just heard from the VA that NDC is insufficient, but the question I would ask from – I'm sorry, I didn't get the name of the person from VA, but is RxNorm sufficient from your perspective based on as you see that migrate and then I'll go back to Wes?

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

Yeah, I think that was Mike.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

This is Mike Lincoln.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Hi Mike.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

Mike Lincoln with the VA.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thank you Mike.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

Hi, you know, NDCs have been added to RxNorm there is not a very good and comprehensive database that NDCs extant although FDA has quite a few of them. The RxNorm system is independent of NDCs. There are mappings from NDCs to RxNorm but NDC are not any sort of foundation of RxNorm by any means.

We work pretty closely with John Kilbourne at the National Library, Dr. Kilbourne is currently the Head of the UMLS section and he's been responsible for a lot of the RxNorm development over the years. We've worked with John for 10 or 12 years on RxNorm.

**Wes Rishel – Independent Consultant**

All right, so here's my question, this is Wes, again.

**Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration**

Hi Wes.

**Wes Rishel – Independent Consultant**

The fundamental notion of NDC going to any actual semantic code set just involves maintaining, continuously updating and maintaining mapping tables, I mean, there is not any systematic way of relating an NDC code to its semantic meaning.

And do we actually think that the immunization substances are defined well enough in RxNorm and NDC? I mean, I'm just concerned you've got this code set that's been specific to immunization –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right.

**Wes Rishel – Independent Consultant**

We could have one of two patterns, either it's kind of long in the tooth and hasn't kept up or it's more accurate and precise than even RxNorm would be absent a lot of work on RxNorm and I'm a little reluctant to push the NDC to RxNorm path unless we know that the resources are in place for maintaining that continuous mapping and that RxNorm is strong enough to replace CVX.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That sounds like a fair summary.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, Cris, this is John, I'd echo that. When we were looking at this one – we have a lot of concerns about historical immunizations that – especially if you get into bidirectional exchange part of that is probably going to relate to historic immunization records as well.

And my understanding from our team is that NDC would be problematic for historic immunizations and you're going to get into data that's been codified already in CVX and I speak from a few points of experience about when you move from vocabulary to vocabulary especially when you change the code set basis of that vocabulary now you're introducing potentially not just mappings but data conversions and other – to use that really doesn't get exposed through certification it gets exposed through dealing with legacy data and I'm very sensitive at this point in time seeing where it has transpired with problem list –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

For transitions of care to introduce yet more –

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

So –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Of that kind of –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think that's right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Certification challenge.

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

Okay, so Cris –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I would propose –

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

Go ahead.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Liz, let me just take this home.

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

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I think what we would propose is that we would support CVX. I think we want to make a note that we understand a general direction in other domains towards RxNorm and we would encourage continued development in that area but until such date as that's prepared the CVX code would be the recommendation from the Implementation Workgroup. Does anyone disagree with that?

**Wes Rishel – Independent Consultant**

Can I make a friendly amendment?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Please do.

**Wes Rishel – Independent Consultant**

And that the plan addresses dealing with historic data.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes.

**Wes Rishel – Independent Consultant**

All right.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes, yes, yes.

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

Okay, Cris, I had just one other –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

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

Cris I had one question?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah?

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

The comment there says should we propose bidirectional immunization data exchange as part of the 2015 or 2017 edition, if we are only talking about getting the implementation guide out that is one answer, if we are talking about making it a Meaningful Use measure that is a different answer. How did you interpret that request?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I would make the argument that the requirement in Meaningful Use is not bidirectional it's just to submit. Bidirectional is more of an optionality issue that people are implementing. So, we ought to endorse the implementation guide for bidirectional for those who choose to use it.

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

Right and my – yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But unless Mike Lipinski overrules here I don't think there any requirement in MU 3 around either the 2015 edition or 2017 edition around requirement around bidirectional.

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

Right and this is strictly certification anyway. So, even –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right.

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

Even if you got to the point where, you know, we required the systems to be able to do that it doesn't mean that MU would require it to meet a measure.

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

Okay, but I –

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

So, in any event this is a system anyway and so that was a question pertaining to certification.

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

Right, I just want to make sure that what Cris said was captured, that this is – we are endorsing a code type and the approval of an implementation guide nothing else.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think that's correct, if we could note that I think then we can move onto syndromic surveillance. Are we good?

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

We're good.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Without objection why don't we move to syndromic surveillance and we should take this in pieces. So, the first part that you'll see is under alternative standards. There are three standards listed two HL7 and one QRDA III. So, of those three options my understanding is that the 2014 requirement is HL7 2.5.1 only but there is no implementation guide to support it.

Since the 2014 edition some public health registries like New York City and Boston have been looking at ways to use data in the HIE for population health purposes, which, you know, is a public good kind of thing.

So, what happens in these particular instances where the HIE is operating in a population health kind of mode the EHRs would be populated by a CDA as opposed to an HL7 2.5.1 transaction. So, there is a desire to give credit for those instances where the exchange is happening using the CDA which has some more clinical richness to it and frankly doesn't require additional work beyond what entities are already using around the CDA.

With respect to the QRDA III specification it's obviously already adopted in 2014 for clinical quality. So, the question in my mind has been then what was the burden on public health. We're going to want to hear from John Travis and others representing vendors about burden on EHRs, but one of the other issues is what about the burden on public health, which is obviously not Meaningful Use covered.

So, under this scenario for syndromic surveillance if we're using a QRDA measure or in general if we're using an HIE for population health a public health agency would need to both send and receive records. At this point CDC is funding a cloud-based kind of platform as infrastructure to be shared for exchange of this kind of data.

So, the viewpoint from the public health folks engaged in this work is that this overall platform that CDC is developing for exchange would do many things but with respect to syndromic surveillance would use QRDA III.

So the recommendation with respect to alternative standards would be – the question for us is would we allow all three and given the state of the industry at this point I think the recommendation from the experts in this space would be to support all three.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information**

**Technology**

And Cris –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, let's start on alternative standards and then we can go to the implementation guide questions.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information**

**Technology**

Cris, this is Lauren from ONC, I wanted to make an addition, it's just that this is only criterion from the 2014 edition that we are proposing to revise to allow these additional standards, the CDA and the QRDA III and that's to try to support those who are trying to attest to Meaningful Use to be able to meet this menu set measure using those other standards since there is no implementation guide for the 2.5.1 message.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thank you, Lauren; you said clearly what I did not. So, the recommendation would be to allow all three. Essentially to allow public health to do the advancement that, you know, clearly is in the local and national interest but it would impose some optionality presumably to EHR vendors.

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

**Technology**

And this is Mike Lipinski with ONC, the other point just for clarification, to get certified you could get certified to just one of those standards. You wouldn't, as an EHR technology developer, have to be certified to be able to transmit with all three standards it's an "or" not an "and" just I want to be clear.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Cris, this is John, you asked me to comment. I think our feedback would differ from the inpatient perspective compared to ambulatory and I know HIMSS EHRA is kind of taken up with the same view.

The objective, if I have my facts right, has been one that has been of limited demand as menu set item and it's fairly unclear from the ambulatory perspective how many states would use query based reporting or go beyond the current standard of 2.5.1 to adopt the CDA or QRDA-based approach for syndromic surveillance.

It just seems kind of hard to say we got a good basis for making a change, you know, maybe that's an argument for the wrong basis is out there as the basis of standard for that, but it just doesn't seem to be of high demand maybe generally and then also relative to other standard options.

The other thing we're hearing on the release 1.9 of PHIN messaging guide on the inpatient side is that there could be significant changes afoot based on the work the ISDS Committee they're looking at going to a 2.0 version that could change significantly in substance from 1.9 and we'd caution making a change to 1.9 if we're going to see 2.0 come about for consideration in 2017 it might cause pretty significant impact on the vendor community to respond to such a change in direction, you know, even knowing 2015 may be voluntary and a lot of us might not be – we're really trying to keep up in good faith on gap development whether or not we pursue certification and come time for it to be required it would be unfortunate to see, you know, a change in direction by the time 2017 comes around.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, I was hoping to box off the transport standards versus the implementation guide, but perhaps we need to talk about both of them at the same time. I agree with you John that there is – my understanding is that there is some energy to go pass 1.9 to 2.0 and that the people who are doing this successfully today are using a Query Health kind of approach as opposed to HL7 2.5.1, which would probably be a more reasonable approach for ambulatory syndromic surveillance.

However, my understanding is that there actually was, you know, an initial direction and then a revised direction from the Policy Committee but at this point it is the case that the eligible provider-based syndromic surveillance requirement would go away to be replaced by a public health registry.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

That may help ameliorate the concern on that side.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I guess the question is if it's going to go away for ambulatory in Meaningful Use 2, sorry 3, John do you have a view about how we would break this down for the 2015 recommendations?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, I mean, that's a bit of a leading question, I would almost suffice to say why make any change at all and again that gets back to kind of the low adoption rate of it to date given the basis of standard that is there and that probably is why they're considering doing away with it so why change it, that would be much ado about nothing it would seem, you know, focus on the inpatient side and predict where you're going if you're going to change the standard. It may not be quite ripe for the change if 2.0 becomes adopted for the PHIN messaging.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, we may have input from others. I'm hearing from John and from our conversation that with respect to the alternative standards since this is intended for full optionality that it really is "or" and not "and."

That if vendors can work with whichever these standard is appropriate the question then is on the public health side, you know, public health wants to do work using CDA via HL7 and they want to use QRDA III which is already something that was adopted as a 2014 standard for clinical quality.

So, given optionality do we have any reason to say that we should not allow the addition of the CDA and the QRDA III standards since they would generate some good on the public health side? So, any reason not to include the optionality with respect to alternative standards?

**Wes Rishel – Independent Consultant**

Wes here.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes?

**Wes Rishel – Independent Consultant**

So, I'm having difficulty with this its "or" not "and." Is it the case that the plan is that no one is going to implement this, I mean, that's it's literally just for certification?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, my understanding is that some EHRs in fact are exchanging data using CDA and Lauren might want to speak to that.

**Wes Rishel – Independent Consultant**

Well, no I'm just saying, with regards to what's required –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right.

**Wes Rishel – Independent Consultant**

All right, if a vendor has a client and a client has a reason either Meaningful Use attestation or some other reason to want to do this then they're going to be doing it presumably with the health authority that specifies one of the three standards not that does all three.

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

Right, actually, I want to – this is Mike Lipinski, I want to backtrack.

**Wes Rishel – Independent Consultant**

Yeah.

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

Yeah, it is – the “or” should be treated as an “and” that's my mistake I shouldn't have said that it would be or –

**Wes Rishel – Independent Consultant**

Okay.

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

For each of them because going forward if you were certified to all three then you would be eligible for gap certification, but seeing that previously you had only been certified to the HL7 standard you wouldn't be able to gap certify to the proposed new one.

**Wes Rishel – Independent Consultant**

Well, I'm – I mean, if in fact there is no plan to require or give a menu choice to doing this for attestation and it's optional, I mean, and it's voluntary not optional but voluntary, then on the one hand it's probably low impact because you don't have to volunteer, but what the heck is the point. I mean, you know, I'm really feeling like we're falling into a trap of doing stuff for bureaucratic purposes with no real impact on healthcare at all zero. Perhaps I misunderstand.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, I think the argument –

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

–

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Go ahead whoever wants to speak up?

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Why don't you go ahead Cris?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Was that Lauren?

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Go ahead?

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

I didn't – yeah, you know, we try not to get too influential here. In Meaningful Use Stage 2, you know, providers have to choose a minimum number of menu set items; I believe it's 3 out of 6 and one of them being syndromic surveillance.

With the standard that we adopt in the 2014 edition you can only use a – your system is only certified if it's certified to the HL7 2.5.1 message, but as we said, CDC went back on their intention and did not write an implementation guide for ambulatory settings.

And so given that there is no real meaningful way for EPs to actually attest to this measure, meaning that they would exclude and we'd like to provide EPs a way to actually meet this measure and actually send syndromic surveillance data, which we do feel is valuable, and as we said, you know, the CDA and QRDA III standards have already been adopted in other places in the 2014 edition and so we wanted to hear from you on how big a lift it would be if we expanded the use of those for syndromic surveillance and allowed Meaningful User EPs to get credit for the syndromic surveillance menu objective.

**Wes Rishel – Independent Consultant**

So, the happy –

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

And that's why we're proposing the change.

**Wes Rishel – Independent Consultant**

So, the happy path here is that certification for 2015 – are we talking about 2015 or 2017 here?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Fifteen.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Fifteen.

**Wes Rishel – Independent Consultant**

I see, so certification for 2015 would include all three, it's an "and."

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

And we're proposing to revise the 2014 edition version of this criterion to also allow the three.

**Wes Rishel – Independent Consultant**

Right, okay, so that the happy path would be that providers, EPs that have implemented the 2014 edition would be able to use this menu item during the period before 2017, would be more likely to because there are more states that accept one of the three than the states that only accept the one.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Yeah and our understanding is that there are some states who are using CDA or QRDA III through, you know, such initiatives like Query Health and, you know, population health.

**Wes Rishel – Independent Consultant**

Right, okay, but fundamentally there is a path by which something actually happens to make syndromic surveillance more – happen more than it does now. It does require, in effect, all vendors to put into their 2014 software the three standards because it's a modification to the 2014 edition requirements is that correct?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But it's a case where it would be an "and" requirement that's optional which kind of makes –

**Wes Rishel – Independent Consultant**

No, I don't get that – I mean, I hear –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

**Wes Rishel – Independent Consultant**

Why is it optional? I mean, it's not – they're going to revise the 2014 edition, this is not a 2015 matter, so we also heard it's not suitable –

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

But –

**Wes Rishel – Independent Consultant**

For gap analysis so essentially –

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

Yeah, but Wes –

**Wes Rishel – Independent Consultant**

Go ahead.

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

I just to interject and maybe alleviate your concern. If the product has already been certified to the current adopted 2014 edition criterion for public health –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

You're good.

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

Then it would already – it would stay certified that doesn't change. So, you would still have a certified EHR.

**Wes Rishel – Independent Consultant**

Okay, so then the likelihood that a given EP in a given state where the state didn't use the current HL7 standard, the likelihood that they would be able to actually select this as a menu item would be limited by whether their vendor had gone back and voluntarily implemented and gotten certified with the other two standards is that right?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

My understanding, Wes, is that that's true. I think it is also the case that there are EHRs today that are using CDA to put data into public health registries for syndromic surveillance and they're not getting credit under Meaningful Use attestation and that this would achieve that goal of including those transactions which are valuable, arguably more valuable to the public health registries than the HL7 2.5.1.

**Wes Rishel – Independent Consultant**

Okay, so that creates some value here. Anyway, so I would just ask John, you know, is it the case that if someone is already using CDA to send data for this purpose would they have to go back and re-implement it because of the new requirement or would they just continue to do what they're doing? I'm not sure my question made sense.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, my understanding, Wes, this is John Travis, would be that, I may be way off base here, but the current basis of specification certified 2014 must be used for use so given the CDA – that doesn't mean that people aren't submitting public health data using CDA they may well be.

**Wes Rishel – Independent Consultant**

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

But they're doing it extracurricular to meeting the attestation requirement for Meaningful Use –

**Wes Rishel – Independent Consultant**

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Recognizing 2014 certification. So, if we were to go back and certify to the use of CDA it would open up that avenue to count. For reporting periods going forward it wouldn't change the status of anything retrospectively.

They already, to me it's very interesting, because either they're not, you know, if I'm an EP using CDA to submit syndromic surveillance data by CDA I'm not using syndromic surveillance as one of my menu set because it's not that important.

**Wes Rishel – Independent Consultant**

Yeah, what I understand is that there is apparently an opportunity for people who are already doing the right thing and submitting syndromic surveillance data to get credit for it through this change.

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

Right.

**Wes Rishel – Independent Consultant**

And that the argument is that it's implementations that have already been done because some people are already doing it.

But, I'm completely confused on whether you can count it if it hasn't been certified, that is if I'm an EP and I've been doing the right thing and my vendor doesn't do anything, because – doesn't change anything because they're already creating CDAs for this purpose am I allowed to count that now as a menu set item? It hasn't been certified. That vendor hasn't been certified this way or does the vendor have to go back and get recertified?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I don't think you would. I don't think you would be.

**Wes Rishel – Independent Consultant**

Would be what?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Mike?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, Cris, I would think that the vendor would have to be certified, I could be wrong.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right I agree.

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

I mean, if you're not using certified EHR technology then you're not – it would be just with anything like any other standard that you could have been using –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Right.

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

That isn't the standard that –

**Wes Rishel – Independent Consultant**

Yeah, so in essence for this good to happen, that is for these well intended EPs to get the proper credit for submitting data to syndromic surveillance via CDA their vendor has to go back and get certified.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Voluntarily under 2015, yeah.

**Wes Rishel – Independent Consultant**

Well, it's not voluntary in a sense that if their client wants to have the benefit of it they don't have a chance to volunteer they either give the client the benefit by doing it –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No, I –

**Wes Rishel – Independent Consultant**

Or they don't give their client the benefit by not doing it.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I get it although, yes, I agree.

**Wes Rishel – Independent Consultant**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Although that logic could be applied to everything around the 2015 recommendation.

**Wes Rishel – Independent Consultant**

Well, I'm not – the whole 2015 thing is kind of screwy anyway that way, but fundamentally the question that I ask is that are there enough folks out there to justify asking this of the vendor when it's like we're going to change the whole thing in 2017 anyway.

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

So, Cris, could we pass through that comment?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes.

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

Because I'm going to have to be a timekeeper for a minute and I think it's a valid concern and we can capture it and then you could restate any additional comments and we could move to the next one just for the sake of trying to get through all the material is that okay?

**Wes Rishel – Independent Consultant**

Sure.

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

Okay.

**Wes Rishel – Independent Consultant**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think that's perfectly fair. So, Liz we're going to need to do just a pass by quickly on the implementation guide and I think we'll find that the electronic lab reporting is the easiest of these three. This is the most complicated one.

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

Okay, great.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, if we could just have brief comments on the – sorry?

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

That sounds right.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I'm sorry I thought someone was speaking up. So, this issue about release 1.9 versus release 2.0, John Travis notes that there is some energy to go in that direction. There is also the issue that Meaningful Use Stage 3 does not include EP based syndromic surveillance. So, this burden would be or opportunity would be on eligible hospitals and not eligible providers that are Meaningful Use 3.

So, the question is should we endorse recommendation of implementation guide 1.9 or should we recommend something different like aiming at 2.0. I go back to John Travis, if you want to speak up on that issue again and if others want to comment please do so.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, I think, you know, that we don't want to have to develop twice and again I say that regardless of any vendor's decision to certify to 2015. They are I believe, we as a whole class are going to try to keep up. We don't really want to see changes in standards twice over the period of 2015 and 2017 for something that we just certified to in 2014.

So, let me put it this way, rest the standard if you're going to adopt something in 2015 let it stand up, if you believe that where things are going, take your counsel of the ISDS Committee and defer it to 2017.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, if we were to defer to 2017 what do we do John? That would say that we would recommend remaining on release 1.1 for the PHIN messaging guide.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Correct, now I realize that may say, well that's going to put it significantly out of date by the time we get to 2017 but the change appears like it's going to be pretty dynamic between 1.9 and 2.0 and, you know, I think knowledgeable stakeholders like ISDS could comment on is that highly desirable as a matter of public policy to wait for that.

You know the reality of it is putting vendors through their pace is on 2015, especially for a voluntary certification. I'm not sure how many are actually going to go do it. It may be the state of affairs anyway that you remain on the de facto majority standard of 1.1 it's not invalid, you know, it remains valid for those vendors that remain on 2014 as their basis of certification.

There is no compelling mandatory reason for them to pursue it now it becomes a matter for development, you know, do I have to develop the 1.9 and 2.0 can I directly deal with 2.0 that's where we're headed.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I'd make the proposal that our comment be that we favor 2.0 in part with a note that the organizations that are successfully doing syndromic surveillance aren't using HL7 2.5.1 in any case they're using Query Health type approaches and given the fact that it's going away for eligible providers but remaining for eligible hospitals.

Unless there is objection I'd make the recommendation we support John's suggestion that we emphasize 2.0 for the 2017 edition which would mean for 2015 optionality. I guess it would mean not recommending 1.9 but then again if it's truly optional would we want to stay in the way of optional – get in the way of optional adopters who want to use version 1.9.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah that kind of speaks to Wes's point don't punish them if they happen to have done it, we have no problem with that, don't make all the alternatives mandatory.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right, so as a –

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

And John how far along are they with the 2.0?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I probably would need to come back and find out more. I understand that they are actually in the proposal stage in the ISDS Committee for 2.0 which suggests it's more than loose talk.

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

And there is enough concretely known to make, you know, our public health reporting folks tell me the changes are significant and so for them to have enough basis to make that statement suggests that this work is reasonably far along at least in the proposal.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, John should our recommendation be to stay exclusively with 1.1 or do you – given the optionality of 2015 do you – is there any reason not to allow someone to use 1.9?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I don't have any issue with the optionality there for those who may happen to have done it. It doesn't, you know, you're not creating – you're not constraining – it's fair, you don't constrain people who have, you don't condemn people who haven't. Quite honestly if we don't have an interest in it, it's optional and it's discretionary we may not choose to pursue it but point at 2.0.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, recommendation would be allow 1.9 but emphasize the importance of 2.0 for the 2017 edition.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Is that fair?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes I think it is.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay, any other comments on syndromic surveillance and we can go to ELR? Hearing none, if we can go to electronic lab reporting and transmission of lab results there is really only one issue here which is support – whether we support the new implementation guide as created.

And I think, at least from all the input that I was able to get talking to ONC and CDC staff and then talking to others who I know are working in this space there is a lot of support for the new implementation guide. I think this is non-controversial.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I would agree.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Anyone have any –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, this is John.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, this is John, I would agree Cris this one didn't draw any big reaction for us.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think if anything people are happy to see the new guide. So, I think our recommendation would be support.

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

It sounds like it.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

All right, Liz, it took longer than we hoped but I think it was a good conversation.

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

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I'm ready to turn it over.

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

Okay.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Sorry, this is Lauren –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Oh, I'm sorry, I apologize, Liz –

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

I think there is one more.

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

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes, cancer registry, I'm so sorry. Yeah, I apologize. So, the issue here with respect to CDS is the question for us is the cancer community is really interested in knowing whether there is a desire to move to C-CDA as the document used for these purposes.

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

And what would meet – I just have a question about that.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Sure?

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

So, are we saying in essence that we would add more information to – it seems kind of illogical that we wouldn't, but I'm just asking to get it real clear, we would add additional information that would be required or they would like to be a recipient of the C-CDA?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I think this is an issue that the implementation guide has been improved to move – it's primarily a technical conformance issue and it's moving from CDA release 1.1 to the C-CDA requirement or implementation guide.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

No actually, this is Lauren, I want to clarify that.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

For the 2015 edition there is an updated implementation guide but it's still based on the CDA. From what I understand from CDC who has put it together it kind of incrementally moves people closer to the C-CDA standard but it not a C-CDA implementation guide.

Looking into the future they are interested in moving to C-CDA and that's I think the second portion for the 2017 edition sort of early solicitation on support or against for moving to C-CDA.

So, two issues here, whether to adopt the updated IG for 2015 and then also support or against for C-CDA.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thank you Lauren.

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

So, Lauren, I'm sorry, it may be one of those days, are you – when we say – so I guess Cris we have to do it on both questions at hand, but at the end of the day is this then leading to the ambulatory provider having to send that document, whichever one, to cancer registries and the cancer registries who are not under the guise of any of these laws have to be ready or should be ready to receive it? I'm trying to follow the logic here, because it's two very different things.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

**Technology**

Yeah, I mean, for all the public health objectives the receiving side, you know, although they don't have incentives on their side if they want to be receiving this data they also need to make the upgrades on their side to, you know, receive the data in the appropriate, you know, version.

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

Right and cancer registries are part of the ambulatory requirements today?

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

**Technology**

Yes, it's part of – it's one of the menu set objectives –

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

The menu, okay.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

**Technology**

In Meaningful Use Stage 2 and there is a version, I think version 1.0 of the CDA implementation guide is what we adopted in the 2014 edition and so there has been, you know, a minor updated version which is now version 1.1. From what I understand and what we talked about with Jim Daniel, Cris it's nothing very major from what I understand.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Correct, correct. I'm sorry, I threw out the red herring around C-CDA I think that's more an issue that the cancer community has been interested in knowing whether there is a desire to move more fully to the C-CDA in looking at my notes, but correct this is technical improvements around the CDA as it exists.

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

It sounds rational to me others?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think these two are less controversial. So, I would suggest we endorse these recommendations.

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

I vote yes.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Sure, this is John.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And Liz I think we're back to our next topic.

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

Right.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Mr. Travis?

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

Great, so, John we're going to give you a real challenge, you've got 37 minutes to get through this.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I'll do my best, Liz.

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

Great.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

So, the first one I think is §170.315(a)(5) demographics we want to go to that slide.

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

It would be 13.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I think it's slide 13, yeah. One that's real cosmetic honestly is adding back date of death, it was there for preliminary cause of death as a 2011 requirement and ONC is just simply proposing to add it back. I would hope that's non-controversial and declaratory.

The one that's perhaps more compelling is preferred language standard, ONC is proposing three options, ISO 639-2 in full, ISO 639-3 or RFC 5646. As we looked at this, you know, we were kind of questioning why move away from the standard. I think that the concern raised in the preamble, the proposed rule was that some of the options provided for not just spoken language but written and, you know, shall I say, handicap accessible languages as well.

The observation we seemed to come to that if you were to pick one of them the third option would be most leveragible, it accommodates ISO 639-2, we've seen it used in global markets as well for EHR vendors it might have, you know, concerns about wanting to look beyond the US realm and support compatibility globally, that was also noted I think even in the proposed rule as best current practice.

So, that's kind of an introduction to that one. I guess open it up for discussion on the preferred language standard. Oh, it also is noted later in other places that it would become part of the common MU data set; we should note that as well. So, that means it's incorporated into any of the outbound C-CDA documents, transition of care, ambulatory summary things like that.

So, my suggestion would be to consider if there is going to be a change consider leaning to the option three.

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

So, I would say John, if we're not hearing from anyone an objection, I'm sorry, I have no idea so I can't give you any input, Cris, Wes, anybody, otherwise would go with your recommendation is my belief.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I've got no comment in addition to John's.

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

What he said, okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay, the next one we've got slide 14 is §170.315(a)(10) clinical decision support other than the Health eDecision's part of it. So, really what's left over are a couple of things, one is a clarification that the EHR vendor must demonstrate capability to use at least one of the more specific data categories included in the demographics criterion, we'd certainly favor that. Quite honestly, I think probably most vendors assume that in their approach to 2014 certification. So, again, probably some by acclamation.

There is also a proposal to refine the applicability of the InfoButton standard relative to vital signs, medication allergies and laboratory values and results not to require it for accessing linked referential information given the real capability of InfoButton.

And then there was a proposal to adopt an update through the implementation guide to the SOA approach to the InfoButton standard. So, I think that again that second item to more appropriately state where the InfoButton enable capability should be used or not used is one I would hope by acclamation given that's kind of the feedback from real world use that ONC got.

The third item I know HIMSS EHRA has argued for allowing both URL and SOA implementations and the proposal seems to be constrained to the SOA. I don't know if anybody has feeling about that.

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

John, this is Mike Lipinski, it's not, it's not constrained just –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Oh, okay.

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

All we're doing here is apparently for the SOA new implementation guide.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Just updating the guide.

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

Yeah, exactly that's it.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay, again, I think that's nothing that we've – I've heard any objection from the vendor community about. So, I think this one is again, you know, unless anybody has any objections I'd suggest Cris and Liz it's as ONC has proposed it all those things seem to be acceptable and sensible.

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

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

It makes complete sense John, I mean, in our setting InfoButton standard is – well, I won't belabor the point, yeah, I agree with you.

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

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I was just going to give an example why, but let's keep going.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay. The next one, slide 15, is §170.315(a)(16) patient list creation, again, there is a refinement to the 2014 criteria for the sake of demographics that the EHR technology has to demonstrate use of at least one of the more specific categories and again I would presume vendors thought that anyway as they approach testing. So, I think that's by acclamation.

There were 2017 criteria questions in there but I think are those out of scope for what we're trying to focus on? There were several questions that ONC raised relative to preferred – to patient communication preferences and preferred language.

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

Right, this is Mike from ONC that's been the – I guess the path we've taken that we have to –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay.

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

I mean, you – as being part of the Standards Committee and we haven't proposed the 2017 edition yet I think you can – you know we'll work with Michelle for you to possibly take on providing – you know, actual recommendations related to those things in the future.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay, when that cycle comes up, okay.

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

Right, right. So, I think other than that this one again is kind of by acclamation relative to the refinement making sense on demographics. Anybody has any objections or comments back?

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

No.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Otherwise, I'll presumably go on.

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

Yes, particularly since it's also related to a frequently asked question I think we move on.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes. All right, slide 16, we have §170.315(a)(17) patient specific education resources, basically the same kinds of things as we saw for the Non-Health eDecision's clinical decision support proposal so removing lab results and values from what InfoButton has to be demonstrated to support, update to the standard otherwise and Mike I think the case here like for CDS is both URL and SOA continuing to be allowed.

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

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

So, I think that this again kind of works by acclamation to be good update, I'm not aware of any real opposition to it and would suggest we endorse them.

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

Sounds good.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay. All right, the next one is going to be a little more involved. The §170.315(a)(20) on slide 17, the implantable device list for UDI, there is a lot here it really kind of involves proposals both around data capture and then for inclusion in the UDI for all the outbound instances of the C-CDA there is rationale given for this that this really supports the FDA's adoption of the UDI regulations as they're starting for the first initial classes of devices by this fall and then expanding for the requirements on the manufacturer's side to do the labeling using the UDI over the next several years depending on rolling out based on different definitions of device classes.

In looking at this and we really tried to think about it by comparison to other places where we have new data capture requirements and how they might be dealt with and the upshot for us is to wonder if it isn't good to first support the intent to enable data capture and providing, you know, more like a patient list or a registry list sort of reporting as the initial thing and then really look to 2017 to more drive the inclusion of this into the C-CDA.

The reason we positioned it that way and I just offer that for the group's consideration is that on the data capture side we're going to be having to look at how this information gets into the EHR, our understanding is a lot of this stuff will come through surgical documentation.

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

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

So, we need to look at how that workflow plays in, is that going to be integrated, interfaced, transcribed, we think that there needs to be a good allowance for different data capture methods without prescription. So, any of the above are possible as long as the format requirements for the UDI to be able to ultimately be parsed out are supported.

There also was a question of supporting contextual metadata about the recording. You know, I think we need to get used to that in terms of the place to start and support being able to provide registry lists or patient lists that could support knowing what patients are on given devices based on the UDI.

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

So, can I ask a couple of questions John before we go any further?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Sure.

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

When we reviewed this in a subgroup at the Standards Committee that was looking at this from a different perspective which was is there a standard available or not, but the conversation that we had during that conversation was that all this was requiring was that we put the UDI into the EMR, it did not – there was no conversation about also then including it in the CDA. Is that buried in here and we just failed to pick up on it or is that –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

That maybe – I might be wondering if I'm not peeking ahead to 2017 and I apologize if I am.

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

Yeah, I – Michael – Mike Lipinski I did not see that and we may have flat missed it.

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

Well, we did –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

There is a product instant template isn't it Mike in the C-CDA, there is a proposal to do that.

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

Yeah, there is a proposal to keep, excuse me, transmit the UDI for data portability, for transitions of care.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes.

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

For the clinical summary and for trying to – the last one escapes me – oh, view, download, transmit.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah.

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

We did put that – we glossed over it during our prior meetings but it was identified, Wes I think was our lead for ToC and for –

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

No, I was actually talking about in John Halamka's group, it's okay, I'm just trying to get straight.

**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 most of us didn't react as strongly in that meeting because what we were thinking is we're already keeping this information electronically and generally speaking on the acute care provider's side and either it depends on what you call it, sterile services, central supply, because we're already required to keep all this information so if there is a recall we are able to notify the patient. So, it's not data that we don't keep today but now that you've gone into this all the places where it could be, need to be available, that's quite a different story than just supporting it in the EMR.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Well, and the other thing I'd offer Liz is that what you're recording not that it necessarily poses a different challenge, but it poses additional capture requirement, I'll bet what you – well, given that the UDI is not implemented yet, is a device specific or manufacturer specific device identifier which there is a transition period and a grace period that early on manufacturers can ask for some abeyance I think for one year under the UDI regulation to allow for the implementation.

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

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

So, you're capturing a device identifier but you may not be capturing – but it raises the question is the UDI going to be an also, probably.

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

Right, exactly.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

And so, I think there is a lot more to the capture requirements than maybe the intuitively simple description of "oh, it's just another identifier."

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

Yes, exactly.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

That plays into how the EHR is going to get it out.

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

Absolutely.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

And we also observed, you know, Wes knows Gaby Jewel well, Gaby shared with me that she thought that the Structured Documents Workgroup of HL7 was still very much kind of in the throes of doing detailed review at least as of late 2013 about the UDI and we're working with the modeling and methodology group on development of an implementation guide on how to manage it.

It really raised some questions for us if it's really ready for inclusion just yet given where that work might be and if the inclusion of it for outbound C-CDA isn't something better suited – we absolutely respect the point of being able to track it manage it and deal with it –

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

Absolutely, right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Notices but for inclusion for interoperability is it really ready for that yet.

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

It certainly doesn't sound like it to me. Others? I mean, Cris for you and I this could be a nightmare. I mean, we're going to do everything –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No kidding.

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

We need to make sure it's available, but, I mean, if we don't even have a standard yet, in the process but not yet, and then if you look at the places where this will need to be in place and the interoperability inside the record much less from the record to outside bodies there is a lot of work here.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I agree, the other issue here is with respect to UDI. I would just be repeating everything you're saying in spades.

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

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But, I'm glad – I think one of the areas we're looking at also is the extension of UDI beyond implantable device and to other kinds of devices which creates another –

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

Absolutely.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Set of problems.

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

I mean that's – right, 100% with you.

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

Can, I, this is –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

All kinds of mobile devices and so on.

**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**

This is Mike with ONC I just want to make sure I capture this correctly. So, if you are required to record UDI in the EHR and the CDA is able to capture it I was not quite – I must have missed what the concern would have been in terms of getting the information from the EHR into the C-CDA?

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

Well, aren't you saying though, John, that even the HL7 standard for how it would be captured is not yet developed?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I think it's arguable that it is –

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Given what we have been tracking and what I had highlighted was you can go read the minutes of the September Workgroup meeting of the Structured Documents Workgroup that they really seem to be doing the starting stages of an in depth review to develop an implementation guide or at least recommending to the Modeling and Methodology Workgroup of HL7 to do that work for managing the UDI and that just seems to be kind of a disruptive signal to the premise that it's ready.

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

Okay, so what I'm hearing is it's not – the C-CDA is not necessarily ready to capture –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, there's one more thing Mike I'll make mention of and this is kind of compelling to me. The proposed, the use of the product instance template I think there is a UUID that's the identifier in the C-CDA that's constrained to be a root UID with an optional extension. The UDI of the FDA does not meet that criteria.

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

So that is – we need more elaboration by example of just how we're supposed to use what has been proposed if it were to be used and again we don't think that's quite ready for primetime and it's just good to kind of draw a breath, focus 2015 on the data capture and ensuring the acquisition is supported by the EHR by whatever means and then move to 2017 to solidify and gel its inclusion in the outbound uses of it within C-CDA.

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

Okay, that's very clear, thank you.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay.

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

We might want to ask, anybody else, because only Cris and I have spoken up, Mike you spoke up, anybody else on the phone want to add to our comments on this particular request around criterion? All right, let's keep going.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay, I think the next thing we've got is the safety enhanced design on slide 19.

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

I'm sorry to interject, John, this is Mike again, I didn't want to leave this on UDI.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes?

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

Are you fine with the additional requirements besides recording and the parsing out of the device identifiers so they would be able to – a user would be able to parse out lists based on that information.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, I think we were good with that.

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

Okay, I just –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah.

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes.

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

Great.

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

So, the concept there John and/or Mike would be that we would capture it in the EMR if we had a standard and then we'd be able to produce a list not dissimilar from the patient list of patients with UDIs is that your question Mike?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah and being able to parse out the device identifier in production identifier portions is what I think Mike was getting at.

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

Right.

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

Right, okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah.

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

Got it.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yes.

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

Okay, great.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Okay, so I think again the next is §170.315(g)(3) and (4) kind of taking the safety enhanced design and quality management system criteria together. The basic questions for comments were should the scope of SED be expanded beyond the existing criteria set, should formative usability test be explicitly required or used as substitutes for summative testing and some other questions around there. Should there be minimum numbers of test subjects explicitly required feasibility testing.

I think I can reflect the general thought of the vendor community that we don't think we should be expanding to other criteria. Then we got in our own internal discussion into the question of formative usability testing, our concern is it only represents a point in time it doesn't accurately necessarily capture the evolution of a what a vendor does to address concerns over time in trying to ensure a full meeting of safety enhanced design concepts.

The other thing that we raised concern with where the documents that are identified in the 2014 edition versions should sufficiently describe usability testing methods and what is identified doesn't provide guidance for identifying the numbers and types of test subjects appropriate for the criteria that are covered in the 2015 edition.

You know I think a long way of saying, we felt like what's there probably is what we're used to, we're not looking to changing it in any material way. I think HIMSS EHRA is observing the same thing and that the vendor community believes there are probably other avenues to consider how to go about looking at patient safety or looking at usability through other aspects of program requirement maybe like surveillance or other activities that ONC would engage in then certification. So, put that out there.

And that maybe this is only something the vendors do care about in one manner of speaking given that it is – it's not an insignificant level of activity to do now, you know, in particular ways there is a lot of openness for vendors to make it a part of what they already should be doing, but question whether or not it should be –

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

Well I think –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

...

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

Yeah, John, and I'm sure others will have comments as well. I think you're right it obviously affects the vendors to the greatest extent, but I can tell you in terms of the hearings that many of us have, you know, participated in the past the usability factor is always on the table and I think there is some empathy from the perspective that we ask our vendors to go very, very fast over the last two years and as we've implemented your tools we've fought the problem of we don't have time to optimize, you probably don't have time to optimize and yet to take our eyes off the usability of a tool is a little – you know, it's sort of ignoring what we've heard from the consumer and myself being one. Others? Mike I know you have your own stuff. Russ how would you respond to that, I mean, Cris how would you respond to that? Is everybody on mute?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I know I'm muted, I don't have great insight on this issue Liz, this is Cris.

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

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I'm eager to hear from others. I really don't have insight.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

And I freely admit I, you know, I'm representing a particular perspective.

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

Yeah.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

So, I respect that there may be other opinions. And we're not saying anything against having transparency and public policy or program define requirements for safety enhanced design and usability testing, it may be more a question is certification the right venue.

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

Well the other question that comes to mind is we always have to struggle with this public versus private direction and that while there is no question in my mind having been to many of those hearings that the usability of the products is a great concern. I also am always concerned about adding additional cost and regulation in the certification process or any process frankly that might actually prevent innovation. So, there is that balance it's extremely hard to deal with.

**Joe Heyman, MD – Whittier IPA**

And this is Joe; I just want to add on that part of the reason that there is diminished usability is because of the Meaningful Use Program.

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

I agree.

**Joe Heyman, MD – Whittier IPA**

So, therefore it just seems like it's hard to require them to improve their usability at the same time that you're asking them to decrease their usability by putting in all these extra requirements.

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

That's exactly right and I think that may be Mike, that's what we say is that from a conceptual perspective we understand the – and please others, please add friendly amendments, we respect and understand the desire of many to hold our vendors to a higher usability standard but in the meantime we're also asking them to add new functionality almost faster than it is possible somehow not to be negative, say it in a way that's not negative.

But I think Joe is right we've created a very difficult environment and the other thing I do want included in the comments is that there is a balance between private and public and we do not want to stifle innovation.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

This is Cris; I completely agree with your comments. When you asked me before I thought it was around safety enhanced design and frankly I have no clue what safety enhanced design is but I sort of worry about the potentially negative effect it could have on usability and I know that's just a snarky remark and not very helpful.

I guess the issue is I really worry in general about the regulations becoming overly prescriptive in which there is a temptation I think, from a regulatory stand-point, to almost get into design of EHRs and I for one don't see a whole lot of success down that road.

I think the vendors need to be held accountable in the marketplace for usability and there are other levers around usability, I'm just not sure how you can regulate good software, just sort of philosophically.

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

Well, this is – I'm sorry.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But, Mike, has some stuff to say.

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

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I mean, I think we all recognize it's a challenge and Mike I want to be respectful I understand the ONC has been asked to kind of solve this problem and it's a tough one but I don't know how you practically can do it. So, I'll shut up. What's the ONC view?

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

Right and just in terms of the, you know, being overly prescriptive I just want to say that, you know, for those that aren't that familiar with the safety enhanced design certification criteria it simply points to standards that already exist via NIST for usability, via FDA for the development of products. So, we don't set any – we're not setting any standards ourselves –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

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

As to what constitutes safety enhanced design and/or usability at this time. So, just some – just wanted to offer that, we're pointing to, you know, consensus-based standards for the most part when we talk about certification to safety enhanced design and even quality management systems.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That's helpful, but in general, Mike, I think our – I know we want to wrap up but I think we should add some – I would like to see some commentary added to say that we sympathize with the difficult position that ONC is in, in needing to respond to public demand to improve usability of products.

The question is the balance of is regulation or market pressure or other kinds of levers the best way to achieve that goal and that we would, I think – I would argue we should support a viewpoint that we observe everything that's going on in the market that will improve usability, that regulation is perhaps only one of those levers and that we not depend on it exclusively as a way to improve usability and we should be careful that in the pursuit of usability we don't cause, you know, unintended consequences.

And, you know, Joe raised the issue that lots of Meaningful Use requirements have slowed down the ability of vendors to work on other things that make them appealing in the market.

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

Right.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I know that sort of a little bit of a long set of comments, but it feels like we ought to comment on it, it's a really critical issue right now. So, I would be happy to, you know, see whatever draft folks come up with and add some language around that for our comments for next week.

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

Given that, Mike, if you have enough if we can try to get to this last – I don't know, I mean, we only have just a couple of minutes, we could either have you explain the last one to us or we can ask people to submit their comments to us in writing related to – if you could just explain what is being asked.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Yeah, Liz, this is John, I could run through that real quick and give a real high level statement if you wish?

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

The last one §170.315(g)(5) is speaking to the need for the EHR to provide evidence really for non-percentage based objectives like clinical decision support utilization, drug-drug, drug-allergy checking, formulary checking things of that nature.

So, this really raises the question and we've seen it honestly come up a lot under audit through the CMS audit contractor and have been asked a lot by our clients about how to provide evidence of this kind.

I think in principle we strongly support the idea of the criterion being there to have an ability to provide that audit evidence because we're honestly being asked to help guide people anyway to do it. I think what we would be concerned about is beyond example and perhaps example align to the criteria that pertain to those objectives, like some of the ones I've mentioned, ONC not prescribe how the EHR does it but the criteria leaves flexibility to the vendor to determine how they can provide that supporting evidence.

We get concerned when it's necessarily prescribed for example that the only way to show evidence of support for formulary checking is to have, you know, evidence that it was on start, during and at the end of the period or that it must necessarily be based on event logging of events firing or any such means as long as valid evidence can be provided.

We would certainly invite good examples from ONC as they develop this criterion and as it becomes a test procedure, but please don't go to prescribe it that I think corals innovation on how to meet it, it also might be contrary to what has been acceptable as audit evidence because I can guarantee you the CMS audit contractor will look at any criterion here and if there is prescription it will become prescription for what they will ask for under audit that would be my biggest concern and that just doesn't seem to be very appropriate for the intent of providing evidence based on how the system behaves.

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

And so the – as I read through this and thought about it too, I guess I struggle with examples of, you know, I agree with your comments about the prescriptiveness of it and what that entails for all of us, but what I was trying to figure out was what Mike were they trying to get to? I mean, is there anything in mind or are you simply trying to set up a criterion that if they came up with a non-percentage based, I guess similar to “yes/no” questions today, is that the idea Mike?

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

I guess I'm not following the “yes/no” question?

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

Well, today we have –

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

I mean, was it turned on or not turned on you mean?

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

Yeah, right, today we have “yes/no” questions right that we attest to?

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

Right.

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

And this is talking about, you know, non-percentage based capability and I was trying to – I was – and maybe I'm trying to go too far, I understand the concept that's being presented here and agree with John's comments, I'm trying to presume where are they going, it's really hard sometimes without an example to say, it makes sense to me, but then it depends on what you're going after potentially.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Liz, I'll offer this, this is John again, an interesting entity to consult with without them, you know, giving away any particular secrets of the audit process would be to perhaps ask the CMS audit contractor to weigh in about what they've determined to be acceptable evidence, because this is going on today –

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

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

In the – by –

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

It is.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Payment audit, so we have a basis for collecting those examples. It would be interesting if they could abstract out, you know, this is the kind of stuff we're seeing that we're believing to be acceptable, audit evidence for clinical decision support being on or for –

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

Right, exactly.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

You know, public health reporting if it's – you know, if that's part of it and there is actual submission.

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

Right and then that would inform our recommendations for the future. How about that Mike?

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

Okay, so, I mean this proposal, you know, is to capture, you know, you already have your automated numerator –

**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**

Reporting and calculation to capture the percentage base and this is a means – and it is definitely, you know, related to auditing and we proposed this actually in the 2014 edition got some really good feedback but we're back trying to propose a more refined approach at this time and the Office of Inspector General has been, as noted in the preamble, has recommended that we propose this as well.

I guess what I'm asking – what I would ask back to John, you gave a great example of one like formularies or even drug-drug interaction checking –

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Right.

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

Where it has to be turned on for the whole reporting period. What do you foresee – I mean, I guess I need to see, besides not an audit log saying it's been turned on and not indicating it has ever been shut off during the reporting period, what would you – are there other – because I'm not familiar enough to know, what else?

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

There can be configuration of the reference setting –

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

We can take a snapshot of that now, is that going to prove on a daily basis – some systems are going to have the ability to provide reference data configuration logging so we know when it was changed. So, there may be the ability on certain things to provide evidence that it was on at the start, it was on at the end, no state changes were logged during, it should be sufficient.

You know the reason I think that the CMS audit contractor be some – you know, again they may not be willing to do that, I can't obviously say that without knowing if they would, but there may be a range of evidence that could provide good examples by objective where this would play in for what is a Stage 2 or Stage 1 objective because I know their audit experience is still Stage 1, because they're auditing program years –

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

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

You know up through probably 2012 realistically right now and not even into 2013 yet. But there still is learning to be built through that which the other thing that I can almost predict would happen is that they would look at any criteria here and potentially then go apply it to what they would ask providers for under audit and, you know, that's the danger of prescription. So, I think, example is very valuable –

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

Right.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

I think prescription could work to head off reasonable ways of meeting the audit request but the auditor goes "now wait a minute that's not what" you know "was said for certification that systems need to be able to produce. I don't see that in what you're giving me now" and that's the last thing I think we want to see happen is an unfortunate level of prescription come out of it.

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

Okay.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

But they could be a valuable source for a good example.

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

Right, so, Mike, we can continue the conversation via e-mail and so on so we can capture it. John and Cris, thank you so much for helping us get through all of this incredible amount of detail. I want to encourage the Workgroup to please look at the other two documents that were sent out with your Workgroup materials, because we are going to be in the process of formulating the final documents back to the Workgroup and we'll be meeting the day before so that will be putting the final touches on.

We absolutely again want to hear from all of you once you take a look at those if something you think is important is not captured please send it to us so we can get it captured. And, I'm going to ask Michelle to go ahead and take it to public comment and then Cris I'm going to leave it with you I've got another meeting that's already started and thanks to all though for the hard work to get us – amazing amount of work got done in a very short time.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thanks, Liz.

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

Thank you, Liz.

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

Michelle?

**Public Comment**

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

Operator can you please open the lines?

**Rebecca Armendariz – 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**

Michelle so this is –

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

Go ahead, Cris?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Go ahead?

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

I was going to ask you a question, so you have a one hour meeting next week on the 23<sup>rd</sup> which is the day before the Standards Committee presentation. As we talked earlier you have two slides one which is what we have so far down as summary comments and doesn't have today's in it, which we would have to add, and then you have what we were possibly going to talk about on the 23<sup>rd</sup> but I don't see how you could get through all the topics scheduled for the 23<sup>rd</sup> and the review of summary. So, I just wanted to put to you as to how you wanted to handle the next meeting so all the members know.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Mike you went exactly where I wanted to go.

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

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I think the question is really going to be what topics, if any, do we want to prioritize. I would open up to anyone on the Workgroup who wants to comment on which ones they think should be priorities but also would love to hear from ONC staff. You could look at the topics listed on slide 2 of today's deck, maybe we could put that back up on the screen.

And you can see that we're looking to review materials and to cover four topics as well as review the summary of comments. Michelle and Mike do I have that correct?

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

Yeah, exactly.

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

So, Cris, I think that we actually had decided with Liz the other day that we wouldn't have time to get through those other comments.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

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

That the next meeting would really be about reviewing the comments that we have thus far and making sure that we have a good final presentation for the Standards Committee, although we highly encourage any Workgroup members who want to comment on some of these topics, because some of these are important topics, to send those our way so that we can include those and hopefully have them in time for the discussion next week.

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

Right so –

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Mike?

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

On that point – and Michelle I think that was our discussion with Liz, is there a timeframe in which we – so we can turn this around like by end of day Friday any comments – on the review of slides to date and that way on Tuesday we could focus more on, you know, the summary of the comments from today and going over any additional comments received by close of business tomorrow I guess if that's the date we would use, which I think we'll have to if we're going to get materials out Monday. Does that sound right Michelle?

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

Yeah.

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

Okay.

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

So just to summarize for Workgroup members who might still be on the line, if you have comments for those topics that we originally had just made for April 23<sup>rd</sup> listed on the screen if you could please send your comments to Mike or me, or Liz, or Cris by tomorrow, I know it's also a holiday for some, by close of business tomorrow, we'll work to include those in the comment summary that we review on the 23<sup>rd</sup> in preparation for the 24<sup>th</sup> Standards Committee meeting.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

It sounds like the only practical approach.

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

And unfortunately, we have to close the line.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, exactly, okay. So, thanks everyone for their attention and we'll look forward to meeting on the 23<sup>rd</sup> and then our report on the 24<sup>th</sup>.

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

Thank you everyone.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And thanks especially to ONC staff today, as always fantastic work, thank you.

**Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology**

Thanks, everyone, bye.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation**

Thank you.