



**HIT Standards Committee
Implementation Workgroup
Draft Transcript
July 28, 2014**

Attendance (See Below)

Presentation

Operator

All lines are bridged with the public.

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

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

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Here.

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

Hi Cris. Liz Johnson? If there is somebody on the phone who has their computer speakers on if you could please turn those off it would be appreciated. Thank you. Anne Castro?

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

I'm here.

Michelle Consolazio, MPA – 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

I'm here.

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

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

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi John. Joe Heyman? Kenneth Tarkoff? Kevin Brady? Michael Lincoln?

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Michael. Nancy Orvis? Sudha Puvvadi? Tim Morris? Udayan Mandavia?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare, Inc.
Yes, here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hello and Wes Rishel? And from the NwHIN Power Team I know we have Arien Malec.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Good morning.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Good morning, Arien. Are there other members of the NwHIN Power Team on?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
I'm here, this is Dixie.

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

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
And are there members of ONC on the line?

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention – Department of Health & Human Services
Kim Wilson.

Scott Purnell-Saunders – Program Analyst – US Department of Health and Human Services
Yeah, Scott Purnell-Saunders.

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

Hi Kim. Hi Scott.

Matthew Rahn – Program Analyst - Office of National Coordinator for Health Information Technology

Matthew Rahn.

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

Is Erica Galvez on? Hi, Matthew Rahn. Okay and with that I'll turn it back to you Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Terrific. Well, thanks to everyone who can attend this morning I know this a difficult time of year and we're struggling a little bit with attendance but this is a great turnout and thanks for Dixie and Arien joining from the Power Team. Today's discussion is to follow up on a discussion from our last session.

Caitlin Collins – Junior Project Manager – Altarum Institute

Again, if anybody on the phone is on the web please either turn down or turn off your computer speakers. Thanks.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Boy, we don't need feedback from me that's a bad enough problem. Today's conversation is a second chapter of discussion around constraining the C-CDA. The purpose here is that, as I think everyone on this meeting knows, as interoperability advances and C-CDAs are being shared between clinical organizations we're finding that there are challenges in terms of reading and more importantly consuming C-CDAs between different organizations.

There are a number of approaches that could be taken to improve that but what's been brought to the Implementation Workgroup is some really strong work around constraining the C-CDA to find ways so that we can consume materials more readily and I don't know Michelle it probably would make sense for us to just walk through these slides a little bit. So, maybe we can go to the next slide, please?

So, on July 9th we received a good summary of challenges. It was a more of a presentation than a discussion at that time with a lot to absorb. Today we're going to be having six user experience presentations that will help us consider constraining issues and then we'll talk about next steps and receive public comment. Could we go to the next slide, please?

So, these are the charges for our group is to determine whether there are usability issues with C-CDA v1.1 specification and the associated implementation guidance that hinder interoperability and if there are issues how can ONC most effectively address these issues including future versions of the certification program. Can we go to the next slide, please?

So, this is a quick summary and Michelle we're not going to go through this in-depth you had asked me before we began the call whether we wanted to go through this in detail, but I think it would be helpful just to get everyone up to speed about what the issues are and if you've had the materials in advance you can read them.

Mismatches in code, vocabulary being too broad for some data elements, inability to distinguish between code system and value set in an HL7 message. If we go to the next page, please? Missing information and inconsistent use of variable NullFlavor and some conversation about headers and how do we handle that information.

We went through that in some depth last time. The intention was to try to find which of these things could potentially be constrained in a way to meet a goal that 95% of the data in a C-CDA could be consumed by a different system upon receipt and we had a really great presentation of the technical issues associated with this and I think, is there one more slide or is that the end?

I'm sorry, there are some additional materials. Sorry, I stopped too soon. You can read these as well. Result code disparities, guidance on units and value representation, interpretation code and reference frames missing, and then a long and somewhat complicated issue on method code or the method that was used to perform a diagnostic test and how that is bound.

And I think that maybe...no, I'm sorry there is more, correct? Two more. So, reaction severity missing for allergic reactions and medication codes provided but nothing to display name or code system name. Now I think that's the last slide with the list of challenges, correct?

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

That is correct.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, thank you. So, we're going to go ahead to the user presentations and just walk through all of them in order and then we'll take conversation at the end. These are, as you can see, from a variety of organizations that I think will really help us, four vendor organizations, American Medical Association and Massachusetts eHealth Collaborative.

So, at this point I think Michelle I would turn it back to you or whoever else will run this from ONC and we'll just walk through these presentations and keep them on time.

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

Yes. So, just a reminder to our presenters each presenter is going to be limited to 10 minutes so I will actually be timing you and I'll let you know when you have a minute remaining. But I will ask you to stop speaking after the 10 minute mark so we can have time for all of our presenters. Once all of the presenters have gone we'll open it up for discussion with the Workgroup. So, Emily Richmond if you're ready?

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

I'm ready, what's the logistics for operating the slides?

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

So if you could just say "next slide" we'll move them for you.

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

Okay. So, I'm going to actually just be reading and will only need to have the first slide available and then...or the first two slides and the rest are just there to help with future folks who couldn't be at the meeting. So, I'll go ahead and get started.

Hello, everyone, my name is Emily Richmond, I work at PracticeFusion and I'm a Senior Product Advisor and also served as a Project Director for our entire 2014 EHR certification work that we did towards the end of last year. Next slide.

Before we get started on some of our feedback and experience with C-CDA I wanted to provide just some facts for the group who may not be familiar with PracticeFusion as an organization. We're currently certified as a 2014 complete ambulatory EHR. We're one of the few EHRs that had our customer base have their EHR in hand as of January 1st this year. So, as a result we're one of the eight vendors who have Stage 2 attestation at the time as of the last time the data was reported.

A little more background we're a cloud-based technology and we offer our EHR completely free to all of our customers.

Some facts about our C-CDA usage, I pulled a little bit of data before this presentation. Right now the ability to send or receive C-CDAs on or off the platform is facilitated via the Direct protocol.

Less than 8% of our customers have sent a C-CDA clinical document to another provider and only 1% of our customers have both sent and received a C-CDA clinical document. These stats were generated after having this feature available on the product for about seven months so just a little bit of context there.

So, I'm now going to go into answering some of the questions that were given to us by the Workgroup based on some of the challenges in the summary that we just saw there is going to be some repeating of information, but I guess it's always good to know that we're experiencing similar issues across different organizations. So, I'll just go through the questions and then we can address some more in the comments later.

So, the first question was what...in our experience to what extent are C-CDA documents interoperable across systems today?

So, for PracticeFusion we have experienced some challenges related to both viewing read only files within the product but there are also limitations that impact the usability of exchanging C-CDA clinical documents as a whole. So, these range from just a simple lack of availability of certified systems that we can get these files from to individual line item variations in the Excel formats, in the data elements variations that result in the data that is sent to one system not being usable in the receiving system in a way that maintains the validity, reliability and accuracy of the data.

So, a lot of the challenges we've seen is where we've said we can potentially work with this data but how many guesses are we willing to take or how much are we willing to make assumptions about the data without, you know, potentially comprising the reliability and accuracy of it? So, it's definitely a challenge that we've experienced multiple times with a lot of our partners.

The next question asks what has been our experience to date receiving, parsing and incorporating data from C-CDA documents sent from other systems?

So, PracticeFusion has tested our system using a number of C-CDA documents that were generated by systems external to our own EHR. We've encountered a variety of challenges that vary across the different documents and in some cases vary even between different C-CDA files coming from the same EHR system.

Putting the receiving part of the question aside for moment, which we really see as a transmission issue, at PracticeFusion we distinguish the different necessary actions related to interoperability as display, parse and ingest. There are difficulties that arise at each stage of that process but all are necessary to achieve true interoperability.

Variances in how missing information is handled also presents challenges and oftentimes these manifest not only in the ingest part of the process but also in the display part of the process as different representations can be displayed in another EHR system in a way that would make it confusing or unreliable to the end EHR user.

What our experience has been to date is that receiving and displaying, and parsing, ingesting C-CDA from external systems require technical interventions for each individual partner which is not a sustainable method for interoperability and results in a lot of time spent on the technical side in order to facilitate this.

The next question asks about specific challenges related to the common Meaningful Use data elements. So, I'm going to go through a few of them and just provide some examples of challenges that we face.

In general, data that has loosely defined code sets or code sets that change often and may or may not be updated in each EHR system on the same schedule prove to be pretty challenging. For the demographics there is definitely variance in how data is represented across systems. For example, the sending system may allow for variables or data elements that the receiving does not. This is an example...

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

Excuse me; I don't think the slides are changing.

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

So, I was told I only needed a few slides so I actually prepared longer written statements. I don't...the two sides I have will not match up with what I'm saying. So, Michelle do you want to...you can just arbitrarily go through the next few slides but they're not going to match up with my statements.

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

Okay, thanks Emily.

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

I can share my written statement as well with the group I just...I didn't realize I needed to prepare a full slide deck so I apologize for that.

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

You didn't don't worry, just keep proceeding.

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

Okay. So, for demographics...sorry, for demographics there are variances in terms of, for example, the number of gender items that one can choose and there are also no requirements for the presence of numeric personal unique identifies which would greatly improve our ability to patient match using the C-CDA.

For diagnoses there are variances in how problems are included in the C-CDA since the standard requires a minimum of SNOMED but also supports ICD-9 for things like encounter diagnoses. There are also difficulties related to the metadata for diagnosis not consistently collected and the lack of things like a start date or an end date that have similar issues and the missing information discussion that we mentioned earlier.

For vital signs the data elements are not always available coded as LOINC and there is a great deal of variability as it applies to the units of measurement.

For allergies we've seen a great variance in severity and onset data collection amongst EHR vendors and this results in difficulties with not only displaying but also parsing and ingesting allergies. For example, if the receiving system requires the presence of a severity and the sending system doesn't have a severity at all we have issues with even displaying that in the EHR in a structured way.

There are also challenges as they relate to food and environmental allergies which aren't currently regulated but are an important and commonly reported part of the patient record.

For medications RxNorm updates are not consistent across systems and this can result in challenges with ingesting should, for example, a receiving EHR system ingest an outdated RxNorm code or suggest to the EHR user that they should update it. This area is especially sensitive when it comes to ingesting patient record medications versus just displaying because of the potential risk related to drug-drug and drug-allergy interactions. Because there is a lack of standardization and implementation there are a lot of challenges in trying to incorporate these external documents.

For lab tests and results there are a lot of variations and difficult to work with due to the massive variance in how labs are sending coded results. With internal coding systems it can be different for the many labs the data ends up becoming not useful or readable in a reliable way by the receiving system.

The last question that was asked was related to what our recommendations would be for improving the interoperability of C-CDA documents?

PracticeFusion greatly encourages more standardization through the implementation guides and identifying interoperability best practices that are created through the collaboration of industry stakeholders including vendors, providers, hospitals and other users of C-CDA data.

We also would encourage improving the test tools that are used for certification to evaluate the C-CDA at more detailed level and not just related to the format of the actual document but also to evaluate the discrete data elements contained within each section.

It would also be helpful to provide more examples to EHR vendors to use during development but it's critical that those examples not represent similar clinical documents but that they try to represent a variety of use cases in systems.

We also feel that it is best to standards and regulations that have a chance to be tested in the real world. Rushing to name immature standards and future regulations will only further interoperability issues as systems will then not only produce variations of a single standard version but also multiple variances of multiple versions of the document. Thank you so much and looking forward to the discussion.

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

Thank you Emily and thank you for staying on time we appreciate it. Don if you are ready?

Don Sepulveda, MBA, MHA – Product Manager – GE Healthcare IT

Yes, thank you. So, hi, this is Don Sepulveda with GE Healthcare, I'm a Senior Product Manager supporting our ambulatory EMRs. We at GE Healthcare support eligible professionals and eligible hospitals. Our ambulatory EHR serves about 40,000 providers across the nation. We currently have several products certified for 2014 Meaningful Use and have implemented those across the nation.

Apologies for no slides today we had a bit short notice so I'll just be providing a verbal statement today and replying to the questions that were provided to us. So, I'll be speaking to those directly.

For question number one in our experience to what our extent of C-CDA documents are interoperable across systems today?

We find that C-CDA documents do allow for interoperability across the systems and they do that quite well and what we see in particular is this is true at the document level and that the ability to receive the information and view it is one way in which it is used we believe quite well and we're seeing some of that exchange from that perspective.

What we see certain challenges around is, with question number two, in the ability for receiving, parsing and incorporating data from C-CDA documents when they're sent from other systems. What we see as long as the data is in the document and it adheres to the standards that a C-CDA document can be parsed fine, however, we do find that standards are not always followed and so that kind of leads to the next question of have you encountered challenges within any of the common MU data elements in particular?

So we do see some challenges there, however, we are able to overcome those with certain tools that we allow our customers that they can adapt to the various formats that they see and that we find in the documents that come from other vendors or HIEs.

If we could...and number three, it says if you could do one thing to improve the interoperability of C-CDA documents today what would you do and where would you focus?

So, primarily the main areas we see is enforcing and really trying to enforce the standards, building upon the C-CDA and what the data is inside the C-CDA and how that becomes more interoperable is really based on how the standards are applied and used by the vendors and so the ability to take in the data that is being sent can be done much easier as long as they are following those standards.

What we do see also additionally around some challenges is the ability to convey information related to the patient as it stands with the narrative sections or lack of narrative sections to really support a clinical summary that a provider is trying to convey to another human.

From a data perspective we feel that it provides the data well but from the narrative perspective we feel that it is lacking in its ability to really provide context for what the patient's conditions may be or what we would like to convey to the other user of that information especially in areas for referrals or transitions of care. I believe that those end my comments for today. Thank you.

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

Thank you very much Don. Udayan if you are ready please proceed.

Udayan Mandavia – President and Chief Executive Officer – iPatientCare, Inc.

Sure, thanks Michelle. Hi, this is Udayan Mandavia from iPatientCare where we're known for our inpatient and ambulatory EHR, complete EHR, certified for Meaningful Use Stage 2 and that's all we've been serving physicians as EPs and the hospitals for more than 15 years now.

And my colleagues will also be sharing our experience which we have accumulated working as one of the three test EHRs as well as serving thousands of EPs about challenges and what we face with C-CDA and our CTO Kedar will be very happy to come up with some recommendations.

But answering the first question we feel that the introduction of C-CDA of the Meaningful Use Stage 2 itself is a huge step towards interoperability. We believe that the challenges, which we will be describing in the forthcoming slides, C-CDA has a great potential and as regards to importing data as structured elements we cannot comment on how many systems provide such a capability for importing elements other than demographics, allergies, medications and problem list.

However, we believe that with the subsequent stages of MU there will be mandates supporting other data elements and also as part of the charge of this Subcommittee the C-CDA will be constrained differently to address the issues arising from the field experience and that's where we'll be seeing true interoperability across the systems.

So at this stage let me request Arnaz who is our Senior Technology Officer to present some of the challenges, what we have been facing. Arnaz?

Arnaz Bharucha – Senior Technology Officer – iPatientCare, Inc.

Yes, Michelle, can you move onto the next slide, please? Okay next, one more. So, when you are talking about interoperability the main thing is importing the discrete data and what is crucial for that is the coded value and that's where we are facing some of the challenges such as we can see in this screenshot we have some vendors who are sending the medication but they are not sending the corresponding RxNorm code. The next slide.

Then we also have instances where the coding system is wrongly mentioned or the one which you can see below that, the codes are not sent in the appropriate mode, we can see that instead of sending the RxNorm in the code section the vendor has sent it in the translation section. So, we had to read multiple notes to extract the data for this one. Next.

One more element of the vitals where ONC is now mandating the LOINC codes and so some of the vendors do not send that. So, again this poses a problem when importing the discrete data for vitals. Next.

And next challenge we have is with the unit codes since standard units are not implemented. So, again, when we are talking about importing the discrete data we have to write additional logic formatting the codes. Next. Next, please.

Okay, one more challenge would be allergy reactions. The allergies are coded but the reactions are not coded with the SNOMED code and since they play a crucial role clinically so this is something that is missing. Next.

Some issues again we are faced with effective time where the proper precision is not sent. Some EHRs do not record the time along with the date and they send something else what is seen in this slide and when it is imported it gets interpreted as recorded as 12 midnight which may not be correct. Next.

Then there have been instances of incorrect application of NullFlavors such as using the SNOMED code for unknown instead of a NullFlavor. Again, there has been confusion of the various NullFlavors when to use unknown or NI, or NA and one such example is when the information is there in the system but it is not to be sent in the particular C-CDA document what would be the most appropriate NullFlavor to use over there. We have had instances where they send unknown which is clinically incorrect. Next.

Then there are some elements again because they're not mandated by ONC or C-CDA implementation guide they have not...people do not send them such as the medication route or the dose quantity. Next.

And one more challenge, with the multiple coding systems specifically in procedures either SNOMED or CPTs are acceptable. Now when EHRs are using only one coding system we have additional things to use to crosswalk to import the data in our system. Next.

Kedar Mehta – Chief Technology Officer – iPatientCare, Inc.

Hi, good morning this is Kedar from iPatientCare, thanks Arnaz for sharing the slides and examples that, yeah, that made a lot of things clearer on how the community is facing the challenges and this is not related to the constraining, but this is something which we hear a lot from our physicians that the Meaningful Use Stage 2 has mandated the use of SNOMED codes for exchanging the problem list and for getting paid the physician needs to continue using ICD-9 codes now and from October 2015 ICD-10 codes. So, they have to do dual coding systems.

We have provided tools in our system and they are quite useful and the physicians are able to very quickly do the double coding, but then again, the question is, is it really required? That's what we have been asked that why do dual coding, which description should I use? So, those are the kind of challenges the physicians are facing when they are in front of the patient there at the point of care.

So, just wanted to pose this question that is there going to be a common or a single element or either of those choices that they can use maybe so that's one humble submission from our side. Next slide, please.

And this is related to the question three that these are some of the recommendations and as mandated by...sorry, as Arnaz shared her...most EHRs are facing the issues with the usage of correct code, coding system or the structure or the formats, or usage of NullFlavors and everything boils down to constraining the C-CDA documents.

So our humble recommendation to the group is to help the community giving an online access to the standardized samples and which are richer in content. And again, those standards, standard samples, can be tested through like...by aligning the Meaningful Use certification process to enforce the standards and also there are so many also optional elements which result into the transmission lose when a document is transferred from an EHR to the other EHR. It would be really helpful if the required elements are identified or there should be minimal optional elements.

And lastly, making online tools available for scoring the documents being exchanged and that would really ensure the semantic robustness of the document sharing. If I, as a physician, get a scorecard with the...on the document along with the C-CDA document the way we are sending the style sheet, if there is a scorecard attached then it will help me, it will aid me as a physician to rely on the content of the document and will give me a piece of mind when I import those documents.

So, these are some of the suggestions we have to the group and with this I would like to end my presentation. Thank you.

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

Thank you very much. I believe Charles is next.

Charles Curran – Senior Product Management – RelayHealth/McKesson

I am, hello, everyone.

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

I'm sorry, it's not Charles, it is Charles I'm sorry. So, Charles you can go ahead.

Charles Curran – Senior Product Management – RelayHealth/McKesson

Thank you. Good morning everyone similar to other presenters I will just be providing testimony with no slides, however, we've created written documentation elaborating on some of our recommendations which can be reviewed as a supplement.

So, with that my name is Charles Curran and I currently serve in product management for RelayHealth McKesson's connectivity business. I lead Product Management for RelayHealth Clinical Solutions Data Platform and Acquisition Tools Group which builds, manages and supports our C-CDA processing among other product capabilities.

RelayHealth Clinical Solutions provides cloud-based scalable HIE, patient engagement and platform services solutions to our customers and partners. So, I will be presenting from the perspective of an HIE who has received and parsed C-CDAs from a variety of vendors.

Currently, some of our HIE customers include hundreds of health systems and hospitals including all customers using McKesson's Horizon and Paragon EHR and a large number of health systems seeking an enterprise patient portal which meets the view, download and transmit functionality.

In addition to that we also support the US Department of Defense as part of the Defense Health Agency's Global Patient Centered Medical Home Initiative as well as tens of millions of patients with secure messaging and health record access. And finally, member organizations of the CommonWell Health Alliance for which we serve as the pilot service provider.

So, RelayHealth is in a unique position to evaluate the current state of Consolidated CDA. In our work both for our health system customers, our EHR partners and the Department of Defense we transact both continuity of care documents and Consolidated CDA documents at a current rate of more than 5.5 million documents per month with that number growing very quickly.

The vast majority of those documents currently conform to the C-CDA specification. We not only move those documents from place to place as part of our health information exchange and direct HISP functionality but we also parse and aggregate the discrete clinical information to a consolidated record which we display both to providers as part of our HIE products and to patients as a view, download and transmit certified patient portal.

We currently process C-CDA documents for a number of acute and ambulatory EHR systems including McKesson's Paragon and Horizon, Cerner, Epic, Siemens, Meditech, Allscripts, GE, eClinicalWorks, NextGen, athenaHealth and many others. So, we have a lot of experience getting these documents from different places.

In addition, in our work as the pilot service provider for CommonWell, we have also had the need to handle C-CDAs from CommonWell members such as McKesson, Cerner, Allscripts, AthenaHealth and Greenway.

So, based on that experience we do believe that the industry is making progress in interoperability and we do believe that C-CDA is helping with that. However, we do note some limitations in the existing implementations of C-CDA at this point in time which impedes the level of interoperability expected by industry stakeholders.

So, in our work some of the things that we've noticed relate both to the document and to the data standard. As a document standard C-CDA currently has multiple limitations. The typical experience of a clinician is to view a vendor specific style sheet but depending on how much information is in there maybe tens of pages long there is no real way to receive a pertinent summary of the clinical status of the patient or to view only subsets of the data such as the active medication list without having to page through multiple screens of information.

And as a data standard C-CDA is poorly constrained in part such that vendor and sometimes EHR specific configurations must be developed to parse critical sections including medications, problem list and allergies, and medication intolerances.

There is such variation in how no known medication intolerance and no known environmental substance allergies are handled that special casing in SNOMED terminology by the vendor is required.

C-CDA does not handle data versioning therefore data correction in the case of errors requires manual intervention and that's a serious shortcoming in my opinion.

Finally, many C-CDA instances have more specificity in the narrative section of each section than in the discrete data section. Because of this some vendors have even proposed that we parse the XML narrative text rather than handle the information missing information in the discrete data section.

So, you know, with that the ONC's proposed performance standard of handling 95% of the receipt C-CDA's would, at this point, require intermediaries such as RelayHealth to accommodate all of the vendor specific variations.

At this stage most EHR vendors have simply developed default to view only solutions rather parsing and handling discrete clinical data. And as I mentioned, we have more details on this in the written documentation that we created.

In our judgment C-CDA is better and more tightly constrained than the CCD standard which it replaced. However, the overall experience of supporting C-CDA has been more problematic than the experience of supporting CCD simply because the timeframe for support was far more rapid.

We implemented more than 325 hospitals between April and July of this year in an accelerated timeframe with the vast majority of these organizations going live in the 45 days immediately preceding the July 1st start date for Stage 2. This is, despite the fact that, you know, McKesson EHRs were certified within three months after the publication of the final rule.

The accelerated deployment was necessitated by the accelerated timeline to certify, test and finalized for general release, rollout to hospitals, locally test, train and certify for production and finally bring technology live to meet a fixed drop dead date.

So, with that our recommendations include to publish more details and constrain specifications and implementation guidance including clinical use cases to address common issues causing variants such as the handling of current and non-active medications, problems, allergies and the comingling of the terms medication intolerances and environmental substance allergies.

Publish conformance tools to accompany the implementation guide to optimize and validate real world instances of C-CDA and a standardized style sheet rendering a C-CDA.

Evaluate standards and implementation guidance that separates clinically relevant narrative content from the accessible discrete information.

We recommend using FHIR to bundle a narrative summary with accompanying discrete resources where alternatively future C-CDA documents could deliver brief clinical narrative separately from the packaging of discrete clinical data without the need to render each section's narrative text or machine abstract the document.

And finally, we recommend that significantly more time (than was allowed for Stage 2 Meaningful Use) be provided for future phases of Meaningful Use and other certification related timelines within regulatory programs. This additional time will allow for the appropriate use, testing, deployment and other activities such as the improvement of implementation guidance and incremental refinements for both standards and implementation. So, finally, I'd like to thank everyone for their time and that's it.

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

Thank you so much Charles. Matt if you're ready?

Matt Reid, MSMI – Senior Health Care IT Consultant - American Medical Association

Yes, thank you again to the Standards Committee for asking for this presentation. We appreciate this. It's very interesting and actually somewhat disconcerting that both the physicians and the vendors are coming up with some of the same issues with the C-CDA I'm going to elaborate on that further through my slides. Next slide, please.

I have two sides here in the beginning basically as an overview of the C-CDA just due to the fact that I will be referencing a couple of these terms basically C-CDA in Meaningful Use specifically addresses care coordination and patient engagement. Next slide, please.

The structure essentially of the C-CDA is that it's designed with a header, a body, a section, a narrative and entries, and again, this is mainly to kind of lay the groundwork for the further discussion. Next slide, please.

So, one of the questions that was presented to us was to the extent are there C-CDA documents interoperable across systems today?

If you dig down into it there are nine document templates that are constrained to produce the C-CDA. However, there is no single C-CDA document template that contains all of the data requirements that are sufficiently necessary to meet Meaningful Use Stage 2 compliance. In fact the C-CDA in the Meaningful Use guidelines has to be implemented together but separately. Next slide, please.

With respect to transitions of care the C-CDA document templates were designed to be open basically allowing for optional sections to be defined in the template by the implementer. This idea of optionality was designed to allow the C-CDA templates to accept and produce necessary documents, excuse me, data elements for the purposes of the center.

However, what we have found is that the optionality though designed in the system was superimposed on poorly constrained guidance. In fact, the generation of the correct summary of documents are left up to the discretion of the EHR vendor within guidance, however, that guidance has been lacking so far, as far as we can tell, and is too broad. Next slide, please.

I have a couple of examples with respect to care coordination; we have been in contact with a physician informaticist that works for the VA. They are in the process of exchanging summary of care documents with a large HIMSS Stage 7 community hospital in their area. The community hospital is using an EHR product from a very large well known vendor.

The labs, medications and allergies are able to be exchanged through the C-CDA, however, and this important, the physician documentation, basically the office note, is not coming across. That is by far the most important part of the exchange of information between two physicians is this summary of care, this note that was generated by one physician sending to the other.

What is also interesting is if there is a disconnect between the type of data or a garbling so to speak of the data between transit the C-CDA itself actually is a method for injecting this information into an EHR as stated previously by some of the other presenters. This becomes problematic when you look at clinical decision support.

The issue is that if the information is not accurate or comes across incorrectly, or again, garbled it's possible that not only would this clinical decision support not function properly it may trigger at an inopportune time.

So, again with respect to the exchange of information yes not only office note is not coming across but the fact that you could inject poor or inaccurate information into the EHR is of great concern to the clinical decision support system. Next slide, please.

With respect to patient engagement the C-CDA is the primary tool for view, download and transmit. The implementation guidance addresses nine document templates in the C-CDA, however, there really are three candidates to the solution of view, download and transmit there is the consultation note, there is the continuity of care document and there is the discharge summary. Again it's up to the EHR vendor's discretion which document template fits this exchange, this patient engagement exchange, and it's by scenario.

So, an example I'd like to provide is if a patient is seeing a primary care physician and they are referred to a specialist the patient of course using Stage 2 measures they have the option to transmit their information and if the stars align and they can get the direct address for their specialist that they are being referred to and they opt to transmit their patient information to the specialist it will come across as a C-CDA.

The issue is that if the data does not come across properly or it is not injected into the specialist EHR properly or it's completely truncated the physician, the specialist physician at that point in time was expecting a good amount of data that usually came across in a faxed format in a traditional exchange.

What we're seeing now is that if it is being truncated and they do not have the information at hand the physician is then required to duplicate documentation and possibly order a new diagnostic test as they don't have the medication or they don't have the lab information from the referring provider. So, this is causing not only workflow interruptions but also increasing cost due to this poor exchange standard. Next slide, please.

With respect to testing and guidance Stage 2 requires 17 different data elements but it doesn't specify say what do when those data are not present. Certified products do have to pass tests that verify that the vendor can create the C-CDA, the template. However, those tests do not verify that the EHR has correctly produced a C-CDA document where there is no data.

As kind of discussed earlier on one of the previous slides, the iPatientCare group mentioned that there are NullFlavor fields available, however, good examples and implementation guidance is lacking and as we've seen before there are various types of NullFlavor, I forget the term, but flavors of NullFlavors that can be used and it's not necessarily uniform across the board.

Certification testing focuses on the creation and transport of the C-CDA but it does not focus on the intake or consumption. And Postel's Law should really be better understood by the industry. And, again for people who don't understand it, it's essentially an idea where you are very liberal with what you're accepting but very specific in what you're sending and that rule of thumb can dramatically help the issue with exchange currently, however, due to the wide variation in implementation guidance and optionality it's not well adhered to.

The C-CDA also focuses on template definition but not the implementation guidance. In fact the Stage 2 data requirements are imperfectly corresponding to the HL7 C-CDA specification. So, you have a program that has named the C-CDA as a primary method for packaging data however it is not mapping correctly and then that essentially is allowing this great variation in optionality. Next slide, please.

I'd like to call out a future Meaningful Use issue that could possibly come up. We were currently seeing C-CDAs in release 1.1. However, that was named in regulation in Stage 2 as a draft standard which really should not have happened. In fact, the implementation guidance, the template structure and possibly the XML could change before it's a normative ballot.

There are discussions about C-CDA release 2.0. Although the 2.0 is largely backwards compatible with release 1.1 which is currently used, if it is named in Stage 3 without further testing there are issues with template versioning where different vendors will incorporate either 1.1 or 2.0 and the exchange information or the exchange inadequacy that we're seeing now will be greatly exacerbated by this movement to version 2.0 and still using 1.1 in the field. Next slide, please.

I'd like to call out an article by the Journal of American Medical Informatics Association. They took...researchers took a sample of C-CDAs from 21 different vendors. They used both NIST and SMART scorecards testing tools. They essentially discovered that over 50% of the vendors had implementation guidance errors and of the 21 vendors that were sampled an average score of 63% was their semantic accuracy. Now, although not every error that comes across either...

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

Hey, Matt, you have a minute left.

Matt Reid, MSMI – Senior Health Care IT Consultant - American Medical Association

Okay, I'm almost done. Not only that every error that comes across in a C-CDA is life-threatening but the missing or erroneous data could cause disruption of vital care activities. Next slide, please.

So, how to improve the C-CDA interoperability, well, because the C-CDA includes dozens of reference vocabularies there should be testing to make sure there's conformance to those vocabularies.

The ONC should identify implementation guidance, constrain optionality more and should produce public samples of the C-CDA documents and sections for people to reference.

And more importantly, CMS and ONC should limit future Meaningful Use stage requirements to ones that are well tested and understood. This may require a look back period to Stage 1 and Stage 2 before future stages are promulgated and that's it. Thank you very much for your time.

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

Thank you Matt. I know...is Micky Tripathi on the line? Okay, I know he had said that he was going to have to join a little late. So while we wait for Micky to join maybe we can open up to the Workgroup for discussion. I know that we're going to lose Cris very soon. So, do we still have Cris Ross? We must have lost him. Okay. So, if there are members of the Workgroup who have questions if you could please use the hand raising feature and put yourself in the queue to ask questions. John Travis?

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

Yeah, thank you, this is John Travis with Cerner hope you can hear me okay. One thing and thank you for all of the presentations this isn't aimed at anybody in particular, but one of the things we have heard is that there is a presumption of what is an appropriate summary that needs to support provider discretion, you know, there are requirements, you know, we've probably all experienced a lot of usability issues with the volume of the size of the transition of care summary in particular and how usable that is.

What do you think...well, number one do you think it is of significance that there is really little consideration given to addressing the size and usability of the summary from that perspective and how to balance a provider discretion about what's included whether that be by having time constraints on how much is provided, giving providers optionality to determine the longitude of what they provide? Have you run into that? Is it something that is part of your recommendations? I don't know that I saw that specifically called out.

And anyone can take that, but maybe I'd aim that at Matt Reid first since he represents the physician perspective.

Matt Reid, MSMI – Senior Health Care IT Consultant - American Medical Association

...

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

And to our presenters you don't need to put yourself in the queue you can just respond. So, sorry, go ahead Matt.

Matt Reid, MSMI – Senior Health Care IT Consultant - American Medical Association

Sure, okay, so with respect to the constraining of the optionality, we believe that it's vitally important that there is essentially more guidance to the use of these templates and what we're actually looking at is that this Meaningful Use Program is very prescriptive in what it's asking for.

We've found that if we are to use the C-CDA document for information exchange there should be more leniency on the physician/patient decision on what information is exchanged. I think that would allow for a much richer implementation guidance set. Physicians right now have to export information from an EHR to another EHR or to a PHR that is specifically required in the program and not all that is necessary.

Again, if this was really left up to the physician and patient's discretion we believe the market would drive the adoption of the actual implementation guidance and standards more closely with what really is needed.

So, from a physician perspective the Meaningful Use Program is far too prescriptive in the actual requirement of the data that is exchanged. It would be very, very helpful to reduce that requirement and allow more flexibility in the program.

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

This is Emily Richmond from PracticeFusion I wanted to respond to the question and air a little bit of feedback from our customer base. We do have a lot of customers who have provided feedback related to the size of the document. For some cases our providers are not necessarily electronically exchanging information but since they have to electronically...even if they are to print certain pieces of information for Meaningful Use it has to conform to the C-CDA standard in terms of the sections and things like that, that's where we see a lot of complaints around the size.

I think electronically, to be perfectly honest, they do not understand the volume but the volume is there. It is certainly a volume issue.

What we've seen since the certification requirements allow an EHR or require that an EHR create the ability to configure the C-CDA when it's a clinical summary we've seen that providers have been using that configurable clinical document option more often than the referral summary which under certification cannot be configured.

So, as an EHR we have the ability to allow them to select different sections that they want to exclude, but unfortunately that's giving them only the option of the section is there, the section is not there and it doesn't give options related to the discrete data elements which is not part of...addressed in the certification criteria.

So, basically we are seeing complaints around the size. What we've seen is people sort of using a workaround and using the clinical document feature creation of clinical summaries in order to reduce the amount of data that's in if they don't want to include certain items and that's how they are reducing the volume for the purposes of C-CDA creation.

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

Okay.

Charles Curran – Senior Product Management – RelayHealth/McKesson

This Charles Curran from RelayHealth, McKesson as well and I wanted to provide feedback to the question. Yeah, I think if I understand the question correctly this is very much in alignment with our recommendation that we should either move to, you know, a FHIR-like approach to bundle a narrative summary at the very beginning of the document with accompanying discrete resources or look to modify C-CDA documents to make it so that you could, you know, make it a requirement for each of those documents to have a non-discrete element that just provides a really complete summary at the beginning of every document that a, you know, clinical user could look at really quickly and get an idea of all the information contained down below.

You know, by relying on a discharge summary, which again still doesn't have very well-defined requirements around it and it can appear kind of anywhere in the document, you're really forcing the users...you know, maybe on the Allscripts document I'd have to scroll all the way to the bottom, maybe on this header document it's right in the middle.

So, getting to more stringent requirements around putting a summary right at the beginning of the document in the same spot every time I think would help a lot.

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

Thank you.

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

Thank you. I think we have Micky Tripathi now so we're going to switch and go to Micky's presentation and then we'll open it back up to the Workgroup for discussion. Micky are you available now?

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

Okay, yes, I am. Hi and sorry everyone that I had to join late. So, I can go through mine quickly, as I'm just skimming quickly through the other presentations it sounds like a lot of the issues that I'm going to talk about have been covered by various other presenters. So, you know, I'm happy to touch on them quickly but it sounds like we can move back to the discussion pretty quickly to make sure that we're addressing the questions that you might have. So, next slide. Oh, good. Next slide, please.

So, the Mass Health Collaborative is a...we're a nonprofit organization that does a bunch of things, but one of the things that we do is that we have a clinical data analytics business and it's in that context that I'm going to speak to the Workgroup today.

So, what we do generally is we take...we aggregate clinical data out of disparate EHR systems from providers who choose to use our service transport it via a wide variety of means depending on what's available and what's the easiest type of transport to get the data to our data warehouse and then just like any data warehouse we run the analytics and we provide various types of user access. So, I wanted to make sure that you understood sort of where we are in the value chain.

The use case that we're integrally involved in is the third-party data aggregation use case and using C-CDAs for that use case. So, we're not involved...we're not a provider; we're not involved in transitions of care or any of those other types of...or any patient facing types of use cases. Next slide, please.

So, the type of analytics that we perform are, you know, a wide variety for, you know, commercial measures, commercial health plan measures like Blue Cross ACO measures. We're certified for Meaningful Use Stage 1 and 2. We do Pioneer ACO measures. We do PQRS all of that so just to give you a sense of the type of requirements that we have for the data that's going to come in from the C-CDAs. Next slide, please.

And we get that from a wide variety of customers some of them very large academic medical centers like Boston, like Beth Israel Deaconess Medical Center, Boston's Children's Hospital or the Brigham and Women's to a wide variety of small practice providers as you would find like in an IPA like the Central Mass IPA or the Adirondacks Health Institute up in the Adirondacks region of New York which is a very rural area lots of small onesie, twosey providers on a wide variety of small and large EHR types of systems. Next slide, please.

And then finally, the data sources we get data from...we get live production data from this set of EHRs right now and from...we're less focused on the claims side so you can ignore that, but just to give you a sense of the types of the different EHRs who are sending us live production data today from the various providers who have contracted with us. So, next slide.

So, the first thing is, you know, the C-CDA has been workable though it is cumbersome and we're getting all of that data from a wide variety of EHR vendors and a wide variety of providers as I just showed. We get something on the order of 400,000 production post encounters C-CDAs per month, you know, it goes up and down but roughly 300,000 to 400,000 per month and then we aggregate that data and then use that for analytics.

So, you know, as that suggests it is workable but as I heard on the tail end of the conversation from a technical perspective the C-CDA is certainly a very unwieldy container but, you know, we've found that these issues can be overcome.

The C-CDA architecture provides a framework for standardized document representation, structured data; there are other ways to go. Sort of FHIR, I think all us see that as being a part of future that's probably got a lot of less overhead on it then C-CDA and it seems to be a direction that the IT industry is taking in general so that would, you know, seem to be a welcome development. But it isn't as if, you know, the C-CDA architecture has proven itself to be unusable from our perspective.

The biggest issue that we've seen is the wide implementation variation across EHR vendors. So, I put in two very large categories the types of variation that we get although, you know, if I showed you the grid of the different issues that we have with each EHR vendor, you know, that would be a very long spreadsheet with tons of specific issues, but I tried to synthesize all of that into two main categories.

One is about data availability. So, you know, what we found is that, you know, one C-CDA does not fit all the needs and I just heard the speaker from PracticeFusion talking a little bit about that. There are certain circumscribed types of C-CDAs that Meaningful Use has driven, certain other types that I think are starting to be contemplated through the S&I Framework and others a set of templates.

What we've found is that the standardized template that people are using can't be, you know, easily modified or easily used for other use cases and so some clinical information isn't available in C-CDAs with certain vendors. In addition, some information is not available in C-CDAs with certain vendors due to the timing of C-CDA generation in the workflow.

So, for example from some vendors we don't get labs or most labs in the post encounter C-CDAs that are sent to us or we don't get E&M codes because the C-CDAs get generated when the clinician logs his or her note at the end of the visit but labs come in after.

Labs, certainly labs that are ordered in that visit are going to come in after or E&M codes are in some practice workflows applied afterward and so those aren't included in the C-CDA. So, some of that is related to the workflows and the triggering mechanisms that are used in the EHRs, but, you know, unfortunately what we see is a lot of variation across EHR vendors and non-standardization of that.

The second is that, you know, data introduced for the Meaningful Use Stage 2 CQMs, this is so, you know, new data introduced to the Meaningful Use Stage 2 CQMs that was not required for the Stage 1 CQMs is not available or not standardized among vendors right now and again that's going to be a market maturity issue I think.

But even in the certified production systems that are out there that have 2014 edition certification we're seeing things like patient communication codes, devices applied on patients, reasons for not performing interventions and, you know, a long list of other things that are not included, you know, right now in the Consolidated CDAs. For again, I think some of that goes back to the, you know, there is not a wide variety of C-CDAs so perhaps that isn't, you know, sort of the typical use for the C-CDA or the use case for the C-CDA which have been focused on VDT and transition of care, so it maybe that, you know, we're trying to jam other types of use cases onto a vehicle that isn't yet developed for that, but, you know, that is some of the gap that we're seeing.

The other big category is, you know, outside of the question of data availability is something in the field or not, is just the semantic normalization part. You know some fields we've found...I mean none of it is perfect and all of it requires, you know; a fair amount of every C-CDA we get from every vendor when we start the process of implementation requires a lot of work going back and forth.

None of it comes clean from our perspective any single time and this is using NIST validators and you're trying to be as clean to the process and as adherent to the process as the process allows or the process has specified.

Some fields we found are rough but can be remediated on our side. So, things like problems, medications, vitals, labs in general if the data is in there we have found that we can work with it. Again, it's rarely clean but we've found that we can either work with the vendor to figure out what the issues are with the LOINC code or figure out, you know, the issues related to vitals, but and then where we can't that we can do the remediation on our side if we end up having to do some mapping on our side we'll, you know, do that from a tactical perspective just to meet them where they are and get the customer what they need.

Other fields we find are often not available or just highly non-standardized across systems, historical procedure information, social history for codes and smoking status, cessation counseling what have you, there are a lot of, you know, a lot of variation there and a lot of work that needs to get done to, you know, to fix those fields that often takes a lot of work both on the vendor side and on our side. Next slide, please.

So, you know, that's just a high-level characterization I know, again, I'm going quickly because I did see the presentations that the other presenters did and I think it covered a lot of the same ground.

From our perspective, you know, two types of recommendations, one availability of standardized templates and implementation guides at least for high-frequency and high-value use cases and perhaps there is, you know, 10 to 12 of those, ambulatory visit, inpatient visit, ED visit, specialist referral, you know, we could pick them off, you know, HIE data aggregation, quality data aggregation I think are, you know, ones that I'm particularly focused on and at least that we've had, you know, the greatest difficulty in getting the C-CDA construct to be easy to use. Again, we've been able to do it but, you know, it hasn't been as easy as we'd like to see in the market.

You know certainly the current work on C-CDA templates and, you know, FHIR profiles looking forward is working on this, but, you know, I think that just needs to be aggressively accelerated and better defined and made available in a much quicker timeframe than seems to be the current timeframe.

And then finally, you know, certification testing focused more specifically on implementation of the C-CDA to support data availability and semantic normalization for these high-priority use cases I think would be, you know, sort of the corresponding, you know, certification piece of that which would give, you know, sort of some greater rigor and discipline to the production systems that are out there in the field. So, let me end there and turn back to the discussion and sorry again for being late.

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

Thank you very much Micky.

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

Thanks.

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

So, we'll now go back to the Workgroup for questions. David Kates has his hand raised and if there are others please use the hand raising feature and we'll get to you next.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Hey Micky it's Dave Kates, question for you and then others might comment as well, but as a secondary user of C-CDAs produced from EMRs I didn't hear any comments about transport and triggering mechanisms for the actual generation of those C-CDAs and was wondering if you had any comments good, bad or indifferent in terms of the...of what you are seeing in the marketplace in terms of EMRs generating those or whether that requires manual intervention and process at the EMR side in order for those things start flowing in order to support the types of needs that your organization has?

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

Yeah, yeah I'm glad you raised that. Yeah, so that...so none of that is out-of-the-box because none of it is required by Meaningful Use. So, in particular, you know, what we require if we're going to use the C-CDA construct for data aggregation, which is what we do, is that a C-CDA is generated at the end of every patient encounter and then either batched and then sent to us, you know, in a batch mode or is sent to us in real-time, but we do need the C-CDAs to be generated at the end of each encounter in order for us to be able to have that complete and comprehensive data set that's needed to run the analytics that we need to do.

So, Meaningful Use doesn't require that as you know for the ToC as well as the VDT use cases that does not require any ability to, even manually trigger the creation of a C-CDA at the end of every encounter that would have the data elements that are required to support the Stage 2 CQMs. So, you know, there's a lot of work that we have to do with each of the vendors on automating that triggering function.

And then on the transport side the other issue that we've encountered again Meaningful Use doesn't require this so, you know, it's hard to blame the vendors it's just there is a lot of variation out there in the market right now, is that we had gone in with the assumption that Direct and as market penetration of Direct, you know, starts to grow that we would be able to leverage that as a transport mechanism for these post-encounter C-CDAs.

It turns out that almost every vendor that I'm aware of is not using Direct for automated data feeds. So, in each case each of the vendors who we work with we end up having to do it via means that are not a part of their Direct solution and instead using, you know, sort of old style interfaces and we either will leverage what an HIE can do so we leverage Hixny in New York, NEHEN in the Mass Hlway in Massachusetts for those vendors and providers who are participating in those HIEs or we'll do a Direct web service directly with, you know, with the EHR vendor or, you know, we do SMTP for, you know, for some large providers surprisingly who find it much easier to just batch up the C-CDAs on their end and then, you know, once a month or whatever just do a large SMTP batch note to us.

So, you know, there are a wide variety of issues there and every one of those is a custom conversation with custom development work required on both ends.

David Kates – Senior Vice President Clinical Strategy – NaviNet

And just a quick follow up, I mean, to the others on the phone, particularly the EMR vendors PracticeFusion, GE, others any either guidance or sort of market demand that you're seeing in terms of being able to automatically generate the C-CDAs at the conclusion of an encounter or subsequent given that lab results and coding, and things that you just heard might oftentimes occur post-encounter signing and encounter completion but just opened it up to the broader group with those comments in that regard?

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

This is Emily Richmond from PracticeFusion, so the trigger events are something that we obviously negotiate and discuss with each of our partners individually. We have found that in general there will be events that to us trigger that this is a patient from which a C-CDA should be created but we do the creation in the evening and then transport via the mechanism that we discussed with that partner.

As Micky said earlier, we do not see Direct as being able to handle the load that's necessary for a lot of these and it's not the most efficient method and therefore Direct is really what we're seeing as an individual provider within our product wanting to send to another individual provider on another product that's a good mechanism for them but it's not really a good mechanism for supporting large transmission loads on a regular basis.

Udayan Mandavia – President and Chief Executive Officer – iPatientCare, Inc.

Hi, this is Udayan from iPatientCare; in our provider community we find that those who are reporting data to HIE have been sort of forcing us to auto generate C-CDA at the end of an encounter and therefore one of our recent releases that's what we've been attempting to do. Again, you know, that's, you know, like answering the question, yes there is a need, there is a demand and we ought to be fulfilling that so that's what we've been attempting to do.

Don Sepulveda, MBA, MHA – Product Manager – GE Healthcare IT

Yeah, this is Don Sepulveda with GE and I would echo that as well. We're seeing that from our perspective where, you know, customers are looking to, you know, need to have a trigger event and automated function to provide that. We do that in our systems today it's a configurable component and allows customers to utilize that if needed.

Charles Curran – Senior Product Management – RelayHealth/McKesson

This is Charles from RelayHealth kind of touching back on the transport question. The lack of a transport standard definitely makes getting all these different customers live in the times that are needed very difficult.

You know in general most of the large vendors do support XDS.b but even within the ones that claim they support XDS.b, especially with the hospital inpatient systems, you find that almost every time it feels like you're helping them build the interface from scratch again or you're letting them know that "yes" you need to include this required piece of metadata in the transaction.

So, yeah a standardized transport method would go a long way towards making these implementations easier. For the most part that takes up a lot of our project time is just getting the interfaces like the connectivity up and running.

Kedar Mehta – Chief Technology Officer – iPatientCare, Inc.

Hi, this is Kedar from iPatientCare, the question is for Micky from an EHR vendor perspective, as Udayan mentioned we have built those capabilities of sending out the data automatically or when the physician completes an order or signs a note the data is sent out.

Now the question is that sometimes the physician needs to amend the document and they again sign the document. So, the same document would be sent twice. So, how are the HIEs equipped to handle those kinds of documents, amended documents?

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

Yeah, so I certainly can't speak for every HIE, but, you know, just speaking for, you know, my business which I know very well, our data warehouse business, and we would just get the most...we would get the most recent C-CDA from you and then we'd break it down into its atomic data elements and we'd matchup with the OIDs.

So, from our perspective it doesn't matter we will update each data element with the most current data that's made available to us in the latest C-CDA vehicle or, you know, we're able to track each of those C-CDAs and keep the most current data from whichever C-CDA it arrived in.

Charles Curran – Senior Product Management – RelayHealth/McKesson

This is Charles Curran from RelayHealth and we do the same thing but this does touch upon one of the limitations in Consolidated CDA that I mentioned in that if someone does put, you know, the wrong medication or the wrong whatever on a C-CDA and sends it across to us there is no good way to then say, you know, that was actually a mistake that, you know, that medication should have never even been on that patient in the first place. So, that's still a difficult thing for us to overcome.

Kedar Mehta – Chief Technology Officer – iPatientCare, Inc.

Yes, I would agree.

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

Yes.

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

So right now there aren't any questions in the queue from Workgroup members. Do Workgroup members have additional questions? John Derr?

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

Yes, John Derr representing long-term post-acute care, a couple of questions and I waited until the end because I know most of this conversation concerns physicians and hospitals and Meaningful Use, but in Stage 2 and the future Stage 3 there is more about the transitions of care between hospitals, physicians and nursing homes, and home care, assisted living and that.

So, one question is to Charles you mentioned Horizon a couple times in your presentation which I know is a home care application. Do you have any experience with the C-CDA or a CCD in the Horizon in transitions of care?

Charles Curran – Senior Product Management – RelayHealth/McKesson

So, when I was mentioning Horizon it was the Horizon inpatient system not the home care system. Within home care we currently support them for Direct messaging but not for C-CDAs at this time. We're in the process of building that out but I don't have any like real world experience, you know, of in production kind of differences within what's going to be in the home care document as opposed to inpatient or an ambulatory care vendor.

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

Does anyone else that gave a presentation, which thank you very much, especially when you had a short time to do it, any experience with CCDs or the C-CDA in home care or skilled nursing? Nothing?

Don Sepulveda, MBA, MHA – Product Manager – GE Healthcare IT

Nothing from me.

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

Am I still on?

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

Yes, this is Micky. No I haven't had any experience in that.

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

Okay, well, that's what I thought but I thought I'd ask anyway since all of the other questions were asked. Just to tell you the vendors in that space are working very hard, there are about four or five of them that did the CCD when they got certified with CCHIT and now they're all working on C-CDAs.

Charles Curran – Senior Product Management – RelayHealth/McKesson

Yeah, our experience with, you know, with Horizon home care is they were very focused first on getting just the Direct message working and, you know, they are attaching C-CDAs within that, but from the workflow that we're supporting right now for them it's purely just the transport getting the message into the other system. But now that they've gotten that live their focus now is on actually generating the C-CDA to come into the RelayHealth HIE and actually parse out and update the patient's health record with information. So, maybe if I do this again in six months I'd have more feedback for you.

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

And somebody mentioned batching and of course when you go to skilled nursing or home care it's got to be almost immediate or before we get people in that transition of information.

Charles Curran – Senior Product Management – RelayHealth/McKesson

Yes.

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

Thank you John. We do have a couple more questions in the queue. David Kates?

David Kates – Senior Vice President Clinical Strategy – NaviNet

This is probably more of a comment, but I'll ask it as a question to the broader group and then again it might be Micky given the breadth of experience, but I'm curious, like there was one comment made by one of the EMR vendors that there is a huge variability in terms of whether standard coding is used like RxNorm codes are used for medications or found, or if they are found whether they're tagged consistently in terms of how they are represented within the XML construct.

And I'm curious whether there is any correlation...whether that's a: a testing issue or whether that's a standards issue and b: whether there is any correlation between ATCBs, between testing bodies?

And I'll just anecdotally mention I know our company went through certification testing and there was a huge amount of rigor on where those types of things were represented within the XML, but subsequently we've seen XML from other vendors tested through other ATCBs and we do see the same inconsistencies.

So, I'm just curious, again it may just be more of a comment but if anybody would like to comment to my comment I'd be interested to hear what the experience is in the market.

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

Well...

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah...

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

I'm sorry was someone going to comment? Go ahead.

David Kates – Senior Vice President Clinical Strategy – NaviNet

I was just going to close it, if you have other comments go ahead and then I was just going to close.

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

Oh, sure, yeah, this is Micky, yeah, I can't really speak to the issue of variation across the ATCBs so I just don't know anything about that.

But in terms of, you know, the other question you had which I think if I understand it right, I mean, we certainly see that there is still a lot of variation...it's hard for us to pinpoint in some cases what is the issue or the source of the variation across the vendors and, you know, perhaps I should know more about this, but, you know, what does...you know, what is actually required data element by data element from a semantic perspective and I know, you know, we're getting better and better as we move to Stage 2, so, you know, part of this is just about what Stage 2 requires and then what the fielded systems and importantly the physician documentation processes are actually doing.

Right, so I think that there is a maturity issue there that, you know, we're probably in the middle of so it's hard to get a good feeling for what this is going to look like two or three just for now even if we do nothing else.

You know that said, the kinds of issues that we still confront, for example, are that an EHR vendor they will send us data for multiple practices let's say, multiple different, you know, multiple customers of theirs who each of them is different...each of them is a different practice, they don't realize or they choose not to, and I don't know what, you know, whether it's one or the other, sometimes they genuinely don't realize that each practice should have a unique OID attached to it for identification purposes and that they should go...and that they need to register each of those unique OIDs with HL7.

Typically, what they'll do is they'll assume that they just need one OID which is for their vendor like PracticeFusion, actually I shouldn't pick on PracticeFusion because I don't know, but eClinicalWorks or AthenaHealth will get one OID for the vendor and then they'll essentially apply, you know, their own random number suffix at the end of that OID that they apply which is unique to their vendor and then assume that is the way they're supposed to do it.

That is not how it's supposed to be constructed and again is non-standard across vendors. So, we, you know, get into this issue of, you know, receiving, you know, data from, you know, 200 practices, ECW practices let's say each one of them is supposed to have a unique OID assigned by HL7 but they don't. They have, you know, some type of unique identifier that we have to work with the vendor on, you know, to figure out how to decrypt so that we can interpret it correctly on our end.

Those are the kinds of issues that, you know, we tend to see over and over again and we see it, you know, with every field that we end up having to, you know, sort of figure out where is the source of variation and without getting into what is the real source how do we fix it.

Charles Curran – Senior Product Management – RelayHealth/McKesson

This Charles Curran from RelayHealth I would just...my own personal opinion on it is that it's both a standards issue and a testing issue. The standards issue and I think probably almost everyone touched on the fact that there are still just different areas that don't really lock down the terminologies that need to be used.

But then it's a testing issue in that I would say that the way most people get passed attestation is they, you know, use stuff where they have data that they can fill in but then when you get out in the real world scenarios all the time we're seeing stuff where we're just getting uncoded values and I don't know exactly how you fix that with ensuring that the data that's actually sent in production matches, you know, what you're doing when you're actually testing for attestation, but it is still a very big gap in that, you know, you'll see like you'll have in the code element they'll have RxNorm and it will be null, and then down in the translation code element they'll have whatever their actual code that they actually have for that piece of data actually is. So, it's definitely still a very serious issue.

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

Right, right, this is Micky, we see the same thing. We'll see, you know, a problem is supposed to be SNOMED they've put ICD-9 in the problem field not in the translation field but they'll apply a SNOMED OID to the ICD-9 problem.

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

And this is Arien, I just want to double down on Charles's comment that what happens in a certification practice or certification process may have only passing resemblance to what's happening in the wild and we see a lot of instances where there was a lot of specificity in terms of the data that was used in the certification process but how a particular practice's code set may be configured may not conform to what happened in that certification process or the actual data that are used may not conform to that certification process.

And as somebody previously said a lot of the tests deal with presence of data not of absence of data and so, you know, the big issue of can you test better but also how do you make sure that the testing that you're doing applies to the "in the wild" EHRs.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah it sounds like the adjunct to the "oh, yeah, you saw the demo."

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

This is...

David Kates – Senior Vice President Clinical Strategy – NaviNet

I'm going to have to drop, I apologize, talk to you later, John. John go ahead.

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

No, I should have raised my head "my head" my hand. I try to keep my head down and my hand up. I wonder if it's been an experience the "in the wild EHR" comment kind of caught me. One of the things I'll observe through certification and we've now worked with two of the testing bodies actually CCHIT and then we're working with ICSA. But I think something that accrues back to the design of the test procedures and test data sets, and I'd be interested in what the vendors on the panel think. It's still pretty happy path testing when you get right down to it.

And I wonder if some of what we're talking about is attributed to the exceptions you do find in the, I love that term "in the wild" or in production use that, you know, I don't know if it's fair for the vendor to have anticipated them or if it's fair for the testing process to detect them, but a lot of the value in the certification is in an almost a belief system of understanding that it's testing happy path it's not testing the exception handling, the exception conditions and the absence of data and, you know, what happens in all of those cases.

What do the panelists...this a little off-topic but it's the testing process for the C-CDA. What is the role of certification in addressing and assuring better handling of exceptions? Because when you speak of constraining the C-CDA you're hoping you drive out the variability but I'm not sure you drive out the exception conditions that can really result and that still is going to be a limit on what certification can really do. Does that make sense?

Emily Richmond, MPH, CHP – Senior Product Advisor, Quality Improvement & Public Health – PracticeFusion, Inc.

This is Emily Richmond with PracticeFusion, just to response to your question, I think that there...at least from the PracticeFusion perspective there's definite understanding that certification cannot test or account for all scenarios. However, there are certain issues with the standards and things that we're required to do during certification that can facilitate and reduce downstream technical efforts that become a sustainability issue.

If there were changes that would occur up front that would reduce the amount of time we have to spend with each individual partner to address some of these issues by even 50% we would be able to handle many more customers and we'd be able to facilitate a lot more of these interoperability situations.

So, I think that there are problems with the standards that can be addressed during certification that would just reduce that, you know, the A to B between testing and what is actually happening in the real world.

So, for example, more detailed guidance around, you know, NullFlavors, how to handle missing information, what sorts of required metadata needs to be available, you know, we're sort of seeing in reality certification did not address the use of C-CDA for the purposes of quality measurement. They only talked about it for the purposes of HIE and the QRDA was sort of used as the quality measurement document, but in reality people are using a C-CDA for the purpose of exchanging information for quality measurement yet there is a lot of missing data.

So, if there is...if we can sort of allow certification to reflect reality closer than there will be the need for less individual attention for each partner down the road. So, that can't be avoided but it can definitely be reduced.

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

This is the Micky. It seems like, you know, there's always going to be the balance it seems to me that Arien was eluding to between, you know, sort of a certification side of this and the attestation side of this that, you know, on the one hand you want the certified systems to be able to handle structured data when it is documented as structured data.

But from an attestation perspective do you want to make as a requirements that they cannot accept any other data should their users choose to enter that type of data and that, it seems to me, from an EHR vendor perspective is that fine balance that they're always trying to walk because they want usable systems.

And, you know, as much as I hear physicians complain about non-standardized data I also hear them complain bitterly when the EHR vendor locks down things so that they can only then enter data in certain ways.

So, I think a lot of this is going to be a balance that we're always going to be walking and there is no clear easy one-off solution that's going to solve it all.

I mean, the best thing I think is from a market perspective the users have to care enough that they want the data to be structured so that they can do higher value things with it that's going to be a general market phenomenon that obviously will take more time.

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

Thank you Micky. This is John again. I'll observe also that the thing that...you know, from the vendor perspective we've learned through many hard lessons and probably all of the vendors on the phone would reflect on as well, we could...probably could not have anticipated...that's why I asked the time context question, for the fact that especially for longtime customers and clients they had a lot of legacy data that needed to be addressed and particularly in the problem list area but also true for some other things that may or may not have been in structured form or may have been in an old code set or other things that have definitely complicated the effort and I think that goes towards, you know, again the level of prescription that may be present in the attestation requirement in that case.

So, that's maybe neither here nor there, but that's definitely a confounding factor in the ease of the interoperability requirement that we're not dealing with pristine data that's newly created going forward we're dealing in a lot of cases with longitudinal data that could be years old and Meaningful Use was a wink in the eye at best when those records were created and we're still having to contend with dealing with them.

Don Sepulveda, MBA, MHA – Product Manager – GE Healthcare IT

Yeah, absolutely, this is Don Sepulveda with GE. I would definitely agree with that we've seen that with our customer base in particular and especially when you provide a highly flexible system trying to rein that back in to support these has been quite a challenge.

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

Dixie Baker has a question.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Thank you. Thank you all for the great testimony. This is really very, very interesting and if you're wondering why we have a couple of people from the NWHIN Power Team we've been looking at query for patient...recommendations for standards for query for patient records so this is very, very useful in that effort.

Micky you recommended accelerating work on the C-CDA templates to correct some of these shortcomings we've heard today and the development of FHIR profiles. The NWHIN Power Team is planning on making a similar recommendation with respect to this query for patient records.

We expect that eventually FHIR profiles are likely to replace C-CDA and with that kind of presumption of where things are headed, given limited resources, how would you allocate your level of effort to improvements in the C-CDA versus accelerating the migration toward FHIR?

And within that same context what would be your highest priority within the C-CDA improvements we've heard about today?

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

So, I'm not sure that I'm the...thanks for the question Dixie, I'm not sure, this is Micky from the Mass eHealth Collaborative, I'm not sure I'm the best person to answer that because I'm focused on such a, you know, specific use case with respect to quality data aggregation which I don't think is, you know, the highest priority or greatest volume use case when we think about health information exchange, which, you know, should be much more, you know, treatment and care focused I think then secondary use focused.

But, you know, that said I guess I'd love to hear from the EHR vendors on this, the concern I have, and the reason I put, you know, the C-CDA piece in there as well is that, is, you know, I just get concerned with the imposition of genuinely new types of approaches like FHIR. I mean, I think it's building, but there's some maturity that obviously needs to take place, whereas C-CDAs while they're still relatively new, you know, if we look at compared to, you know, other types of protocols there is, you know, a growing market understanding of them and a framework at least for pushing those forward.

So, I guess I get concerned, you know, about saying that we shouldn't advance the C-CDA architecture significantly in deference to, you know, what we hope is going to be FHIR profiles or, you know, implementable FHIR because I think, you know, if we think about what are the levers that are going to, you know, sort of bring that to the market aggressively, you know, Meaningful Use Stage 3 there are still a lot of questions around that, around what the timing is on that and frankly there are a lot of issues in the market about, you know, about how strong a lever Meaningful Use Stage 3 is going to be, given, you know, sort of the misalignment between the decreasing incremental payments to providers and the increasing requirements that could be a part of Meaningful Use Stage 3.

So, I guess without being able to give you a numerical, you know, response or a quantitative response on that it seems to me that we need to keep pushing forward with the C-CDA construct and developing that as much as possible because that's what we've got right now and the market has an ability to implement that stuff and hope that the transition to FHIR can happen, you know, in a roughly, you know, near-term timeline but it seems like there is a lot of maturity and the market development that needs to take place before we can really count on that. But, I'd love to hear from the EHR vendors on this.

Charles Curran – Senior Product Management – RelayHealth/McKesson

This is Charles Curran from RelayHealth I think I pretty closely share Micky's sentiments. I think everyone has put a lot of investment into C-CDA and although not in perfect and needs improvement it's definitely a good place and I think with some tweaks here and there we can make it a lot better.

That being said I think long-term FHIR is probably where we want to move to. But given all of the stuff that the different EMR vendors and HIE vendors need to build just to support what looks like is coming down the road in Meaningful Use Stage 3 I'd get really nervous about making, you know, support of FHIR a requirement for Stage 3.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Well, one of the concerns that we have is that we are presuming that EHR vendors would prefer to support a signal stack versus multiple stacks in terms of transport so that was really what...yeah, and avoiding having to support both in other words. Thank you, thank you. Anybody else?

Don Sepulveda, MBA, MHA – Product Manager – GE Healthcare IT

Yeah, this is Don Sepulveda with GE and I would just, again echo the same thing, you know, we need to continue building our experience with the C-CDA I think in the marketplace and, you know, adding onto that and getting a better use of what we have today is going to be important, you know, we're all looking at FHIR and would agree that it's going to be coming and it will be good, but it's...time to get there and the things that we need to be able to do between now and Stage 3 are going to be most important. So, we just want to sure that's understood.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Thank you.

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

John Travis has his hand raised, but...

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

Oh, I...that was my prior question Michelle, sorry, I can take that down.

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

No, no I assumed I just wanted to check.

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

Okay, thank you.

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

So there are...there is no one else in the queue does anyone else have any more questions? Okay, hearing none I think we've now lost our Chairs so I'm going wrap up for them. If we could go to the next slide.

So, thank you very much to all of our presenters today we really appreciate you taking the time and sharing your experience with us.

What our next steps will be are to summarize what we heard today and try to come up with a few recommendations based upon the presentations that we heard for how we could possibly think about constraining the C-CDA and compare those to what we heard during the presentation on July 9th to come up with a set of recommendations that can be provided to the Standards Committee at their August meeting on August 20th.

So, our next meeting is August 11th and we will be working to summarize what we heard today. Any other comments from the group before we go to public comments?

Okay, hearing none, thank you again to all of our presenters. Operator can you please open the line?

Public Comment

Caitlin Collins – Project Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-6007 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment please press *1 at this time. We do have a comment from Steven Waldren, you may please proceed.

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

Good morning, this is Steve Waldren from the American Academy of Family Physicians. I want to thank everybody for taking up this particular topic. I think this is one of the most important topics if not the most important, because I think it deals not only with the interoperability but also the usability of these products.

Two things, one in response to one of the first questions around what should be in part of the summary, this is something that we took up back in 2007 and 2008 with many different specialties and what it came down to is has to be clinically relevant which at this point means that it requires some clinical intervention to determine what is relevant.

I think the assistance can set up some presets based on the reason for exchange such as the patient's diagnosis, the actual reason for the actual exchange and where the destination is going based on those you can start to kind of determine what those are. But I think until we define what those message sets really are it's hard for us to define the standards that are needed to support those in any meaningful way.

We heard loud and clear on the need to not rip and replace relative to the Consolidated CDA and that worked, which we understand, but we also are concerned about the fragility of the standard that was brought up in spades here in the call today and we think there has to be a lot more work if we want to get to something that is wildly adoptable.

We do like the direction of FHIR but also agree that that's an unproven technology as of yet and we need to continue this work here.

I would encourage folks to focus more complete solutions in core so are there smaller things that can be done that go much deeper and make sure that they actually work in the real world as opposed to keeping a wide breadth and making sure that we have much more different templates for people to use.

And the final thing I want to make a point of, as you think about what these recommendations are, I'm concerned that providers have lost a lot of power because of Meaningful Use. With the adoption rates at the level they are they really are dependent upon the vendor because there is no ability to convert their data from one product and move it to the other. So, whatever the solutions that they're able to do are really what their particular vendor is able to do. So, we encourage more on the certification front to make sure that these products actually work for our members. Thank you for taking the time.

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

Thank you, Steve and it looks like we have no other public comment. So, as a reminder, thank you everyone we really appreciate our presenters sharing your experience with us today and we will be summarizing for our next meeting in preparation for the Standards Committee in August. Thank you and have a wonderful rest of the day.

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

Thanks.

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

Thank you.

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Thank you.

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

Bye.

Meeting Attendance								
Name	07/28/14	07/09/14	06/23/14	06/11/14	04/23/14	04/17/14	04/04/14	03/21/14
Anne Castro	X		X	X	X	X		X
Christopher Ross	X			X	X	X	X	X
David Kates	X			X	X	X	X	X
Elizabeth Johnson			X		X	X	X	X
Gary Wietecha								
John Travis	X			X	X	X		
John F. Derr	X		X			X	X	X
Joseph Heyman	X		X			X	X	X
Kenneth Tarkoff								
Kevin Brady			X		X		X	X
Michael Lincoln	X		X		X	X		
Micky Tripathi	X							
Nancy J. Orvis								
Robert Anthony								
Sudha Puvvadi								
Tim Morris								
Udayan Mandavia	X		X					
Wes Rishel			X		X	X	X	X
Total Attendees	9	0	9	5	9	10	8	9