



Joint HIT Policy and Standards Committee

Jason Task Force

Final Transcript

October 1, 2014

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 joint meeting of the Health IT Policy Committee and Standards Committee for the JASON Task Force. 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 will now take roll. David McCallie?

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

Here.

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

Hi, David. Micky Tripathi?

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

Here.

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

Hi, Micky. Andy Wiesenthal?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Here.

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

Hi, Andy. Arien Malec?

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

I am here.

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

Hi, Arien. Deven McGraw?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Here.

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

Hi, Deven. Gayle Harrell?

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

Here in sunny Florida.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP

Huh, that's not nice.

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

Hi, Gayle.

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

Rub it in why don't you.

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

It's sunny in Oakland, too.

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

Josh Mandel?

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

I'm here.

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

Hi, Josh. Keith Figlioli?

Keith Figlioli, MBA – Senior Vice President, Healthcare Informatics – Premier, Inc.

Here.

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

Hi, Keith. Landen Bain?

Landen Bain – Healthcare Liaison – Clinical Data Interchange Standards Consortium

Here.

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

Hi, Landen. Larry Garber? Larry Wolf?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Here.

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

Hi, Larry. Nancy Orvis? Tracy Meyer? Troy Seagondollar?

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

Here.

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

Hi, Troy. And Wes Rishel?

Wes Rishel – Independent Consultant

Here.

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

And is Debbie Bucci on from ONC?

Debbie Bucci – Office of Standards and Interoperability – Office of the National Coordinator for Health Information Technology

Yes I am, right here.

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

And Kory Mertz from ONC?

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

Here.

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

Hi, Kory.

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

Hey.

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

And with that, I will turn it back to you David and Micky.

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

Okay, great. Hi everyone, this is Micky Tripathi and welcome to the next exciting episode of the JASON Task Force. Today we're going to discuss sort of our first, very rough written draft of the final report. So, hopefully you all had a chance to look at it. As you'll see, it's fairly dense and as much as we sort of thought, oh, we really need to take this from PowerPoint and put it into a Word Document, because that will be sort of an easier way of explaining it, it's a difficult set of issues to crystalize and put down crisply, regardless of the format that you use. But, we've taken a first shot and hope to get a lot of good discussion in your feedback on the report.

So, this is the first look for the Task Force at this draft report. We, again, just in terms of timing, we have the October 15 joint meeting where we'll be presenting the final recommendations. The anticipation is that we'll finalize this written report and then once this is stabilized in terms of the content of it, we'll work on a set of parallel slides that will be what we actually present at that October 15 meeting. And then we'll submit the written report as well that the...both the Policy Committee and the Standards Committee members can read in advance. So, in terms of a structure, that's what we're thinking about.

We do have...we have a good amount of time between now and then, so, I think it seems to me that we're in pretty good shape in terms of having at least a written document here that we can now all start looking at. We have one more Task Force Meeting a week from today, I think, but again, we have up until, I'm just going to make up a number, up until October 10 or 11 to finalize our inputs to be able to give it to ONC so they can begin the distribution to those...to the Policy and Standards Committees.

So, for today, what we wanted to do, and I'm going to turn it over to David for a second for any high-level thoughts he has to kick us off. As I said in the note, what we want to do, we divided this into, you know, we'll have a summary of the report and then we've divided it into assessment and recommendations, because you may recall sort of in the presentation of preliminary recommendations we had, we had an upfront piece on sort of observations and findings, which really weren't about recommendations, per se, they were just sort of our critique of the JASON Report.

So, we called that assessment in this written document, had four or five of those, which were really just our observations and things we wanted to make note of. And then we have the recommendations, which I think there are seven or eight of those, which we've tried to sort of structure in sort of a logical, as well as sort of a priority order.

David and I talked in advance and we thought that it would make sense for us to not cover the assessment line-by-line and either take your comments on that sort of offline or maybe we can address those on the next call, but we think it's really important to dive down into the recommendations with the time that we have, so that we can really dig into those and get some good discussion and your feedback on those. But let me pause here and turn it over to David for any introductory remarks he wants to make.

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

I think Micky you covered it well. The process of turning the slides and all of our discussion into a document is a messy process, so hopefully we've managed to keep track of the major points that our group has surfaced. But be on the lookout, in case we dropped something or if we have interjected stuff that doesn't belong there. So, apologies if it's kind of relearning what we went through before, because we tried to put it into something that was more digestible based a little bit on the questions we got back and a little bit just on standing back and reading it through a number of times and trying to tell a little bit more of a story in the recommendations that people can follow. So, we anxiously await critique, and the work is on anxious. It's...this is hard stuff to try to get right.

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

Right.

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

So, one...Micky, do you mind if I just run through sort of our glossary notions just up front, so that we...

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

No, no, please do.

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

So, one of the things we've wrestled with is that we used a bunch of terms somewhat inconsistently in our previous presentation, we used them without a whole lot of definition. And I don't know if this is going to work or not, but what we tried to do is to come up with a set of five sort of important terms that are defined in Appendix A in the document in the glossary. And you don't need to swing to that, I'll just run through them really quickly here, just to alert you to keep an eye out for them in our discussion today and detect inconsistencies or if you think these are wrong terms in the way we're using them, speak up, because I think we may try to organize our slides around this kind of progression of terms.

So, the key terms that we've identified are: first is something we're calling the coordinated architecture, that is the loosely coupled architecture and then define how that works. And the coordinated architecture is built on the public API, and we have some definitions in there of what the public API is, that's at a high level, it's a mix of some standards plus some obligations to expose those standards in a public way.

Then we coined a phrase called the data-sharing network, you'll see that abbreviated in the document as a DSN. A data-sharing network is essentially a market driven organization that puts the public APIs to use in a way that's consistent with the coordinated architecture. And the idea there was to capture the notion that just having an API and just agreeing to expose it doesn't make interoperability happen. Some bodies or some group has to put together a network to take advantage of those APIs. And the network, as you know, deals with some of the complex operational issues of getting licenses in place and trust frameworks and data-sharing agreements and business associate agreements and things like that.

And then finally we have core data services and core data profiles as the technical side of what the public API exposes. So, we had used core API and core services and core profiles, we used a bunch of terms somewhat inconsistently, so we've tried to be consistent with the notion of core data service and core data profiles. And a core data service would correspond in an implementation to FHIR, to a certain subset of FHIR and core data profiles would be those profiles that describe how that FHIR service works.

So, at a high level, is it...Micky, is it worth getting feedback on whether that...those high level concepts resonate with the group or do we just want to dive in to the recommendations?

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

I guess if there are any high level, it's very difficult to throw out those terms and not have deep discussion of them right away. But if there's...I guess, if there's high level, and maybe we should step back and also say, if there's high level in the document itself and the structure, we can talk about that as well. But then, I think that these will sort of come to life once we dive down into the recommendations.

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

Yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Hi, so it's Larry and I want to jump in right off to say I think these are great. I would like to elevate the terminology from glossary to maybe something like key concepts, because we've really organized a lot of our thinking around these and that they should be highlighted early at the beginning rather than just at the end. My two cents.

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

Okay.

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

Yeah, that's...Larry thank you, that's great input. We actually had it that way at one point in our working draft and it was sort of getting in the way and so we just moved it out of the way and it stayed back in the appendix. But yeah, let's see if you still feel that way when we're done and I think that's a very good suggestion. It may be the way we organize the slide presentation also, that can be different than the document.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yup.

Wes Rishel – Independent Consultant

Can you just say why the word coordinated is included with architecture?

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

Umm, yeah. So, well let's do that when we dive into bullet number 1, because I think our recommendation number 1 or number 2 I think will explain where coordinated comes from.

Wes Rishel – Independent Consultant

Fine.

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

So, if we don't address it, bring it back up.

Wes Rishel – Independent Consultant

Okay.

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

And this is Troy Seagondollar, I just wanted to comment, you know, as I read through the document, everything you described, it being dense and very complex and we're going to need to abbreviate this, how are we going to put this into a...? All things that were running through my mind, I kept thinking, wow, this is really deep. So I think the process that you're proposing as we go through this is right on spot. Thanks a lot.

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

Good.

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

Right, thank you. Well, the New England Patriots did me a favor this weekend and gave me more time to work on it than I thought I would have, so...and gave David less time.

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

Yeah I...if there's any anger in the prose, it's from the words that Micky wrote.

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

Right and any joy is from David.

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

Okay, why don't we...

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

Sure, should we dive in?

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

...just dive in. Yeah, are you going to do number 1?

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

Yeah, David, maybe I should do 1 and 2 and then 3 is where we start the coordinated architecture discussion.

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

Yup.

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

And you can pick it up there. Okay, so, I'm on page, I know this doesn't lend itself to the WebEx. So, this is page 8, the top of page 8, beginning with the recommendations. So, the first recommendation is about what it is that we're doing, sort of the level at which we're doing...making the recommendations and trying to introduce sort of the overall concept and then what should happen next, essentially.

One of the things we want to lay out is that this is a very high level sort of view of this and what we think needs to happen next is that the FACAs should dive down into it, to take it down one more level in order to sort of crystalize some of the ideas, confirm some of the things that we're recommending here. And then make it a little bit more actionable, as we think about sort of the dovetailing with the ONC roadmap and what we think it's going to take to accelerate the work toward these sort of components that we're talking about here.

So the recommendation itself, as you can read, is about ONC should take immediate action to motivate a public/private vision and roadmap for a coordinated architecture to target enabling...encouraging market forces, so focusing on the market force aspect of this, which is, in our view, fundamental, that can leverage a new public API for exposing core data services and data profiles.

So the idea is, we're presenting a high level blueprint, as that first bullet says, that's aligned with the JASON vision, to take into account...but, we think that where it's...where we add something the JASON vision didn't have was trying to adapt and take into account market, business, legal and other constraints. Which the JASON Report specifically said, they recognize that they're important, but they weren't going to tackle them.

The second is that this is addressing a...one of the recommendations that was in the JASON Report was to say that we believe that operationally defining an initial, sort of the key concepts here, some key words, initial coordinated architecture aligned with the JASON vision is achievable in accordance with the JASON recommended 12 month timeframe to develop...for ONC to develop an architecture plan. So, the recommendation from JASON was, within 12 months, ONC should recommend a plan. We're saying that we think that that's achievable along these lines.

More focused work is needed, though, to take these recommendations, which are frankly coming out of a Task Force that's sort of a group of people who were able to meet what, 6 or 7 times. We think that it probably needs a little bit more engagement, so the idea here is that to take these to the next level and to validate some of the key assumptions, we really should have the FACAs and some working groups really dig into it a little bit more over some time period, perhaps aligned with sort of the schedule for feedback into the ONC roadmap over the next few months. The idea here would be to have some workgroups really dig in, perhaps one on the standards side, one on the policy side, dig into this and then the output of this would be to identify operational execution activities that need to be performed to take it to the next level.

And then we just want to point out that FACAs are not structured to perform operational activities. So the idea is that the recommendations coming out of this would set ONC up to perhaps, and again, this is anticipating would see what would happen out of that process. But anticipating that perhaps ONC would then be in a position to perhaps contract with an SDO or other well-accepted, operationally active consortium to establish and maintain the specifications for public API, core data services, core profiles, constrained as we define them later here in the recommendations.

So let me pause here on this one and David, I don't know if you have anything else to add, and open it up to the workgroup.

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

No, I...go ahead and get their...other reactions. I think it's self-evident.

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

This is...

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

A lot of words.

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

This is Arien and I'm...maybe it's just that these are later defined, the notion of core data services and core data profiles. I'm just glancing through...

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

They are later defined.

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

...define essential services, so I've been in pre-planning for the architecture API and services workgroup, pre-planning for some essential services like identity, authorization, security services. There may be some additional services that aren't envisioned in core data services that are nonetheless essential for the coordinated architecture.

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

Right. I think we touch on that later, I think we call them cross-DSN services or something, so maybe we should hold that thought until later and see if it's covered.

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

Okay.

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

Yup. It is, just one comment on it. Arien is, and we may not have this defined well enough and maybe it's too deep to even bother with, but the thought, a little bit was that some of those particular capabilities are often functions of the network itself, and may differ depending upon the different networks. So, a network that's batching up data for a population health management system may use a completely different model for authorization and authentication than say a pluggable, modular network.

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

Okay.

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

So, that was one of the reasons for carving them out, but we can revisit that. And...I mean...

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

There would need to some notion that there are some essential services that any actual network would need to provide that may not need to be rigorously defined in this context, and maybe you've got that later on and I'll hold it.

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

It's a great point so let's be sure that we track it, I agree.

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

Are there any other thoughts on this recommendation?

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

Yeah in terms of the...this is Josh. In terms of the process that we’re describing here, I’m just wondering if it’s intentional that we haven’t mentioned the Standards & Interoperability Framework as part of the process with FACAs and standards development organizations.

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

Umm, I mean I think it is intentional to the extent that it seems like there are two pieces to this. One is that it seems like some more focused work is needed to get this to the point where it can be, somewhat more detailed so we actually are able to sort of distill some clear actions and activities that would need to come out of it.

I think the second thought is then, this was related to the idea of ONC perhaps contracting with an SDO or other industry consortium, is the idea that this has probably got to be a very focused, deliverable oriented kind of activity, which is a little bit different than the S&I Framework, which tended to be a collaborative exercise that essentially took the inputs and participation of whoever showed up to develop whatever they could in a little bit more unconstrained way, and I think the idea is that this needs to be a lot more constrained and a lot more focused on some deliverables. But, David, is that a fair way of characterizing it?

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

Yeah, that’s the discussion that we had, I mean, we’re trying to stay a little bit generic so that we don’t...we leave room for discussion and thought and refinement, so we made the point where we...I think we had in one of our slides a suggestion that the Data Access Framework could be a candidate for the convener of some of this work. But, the critical thing is that it needs to be something that has much more stakeholder participation than the typical S&I project has had so far. So, if it is to be S&I, my opinion, not captured in this document probably, but it needs to be S&I with a different approach that’s driven more by appropriate stakeholder engagement than by mere process, which is what is happening...

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

Yeah, so that last piece to me seems worth capturing explicitly...

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

Okay.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

...unless you think it’s politically unwise, but that’s part of our thought process in deciding this and it might be good to say that explicitly.

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

Yeah, and Micky, did you follow that? That might be a bullet to add in here or to refine...

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

Yeah, I was just going to ask for a restatement of what that key point was.

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

Josh, why don’t you say it, if you don’t say it, I’ll say it, but...

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

Well, I’ll just paraphrase actually what Micky and David just said which is that we would really want a focused engagement that included the right stakeholders who came to the table with a clear set of goals and way that perhaps the Standards & Interoperability Framework hasn’t consistently been able to produce.

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

Yup, okay.

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

Yeah and I would probably leave that as a...accentuate the positive requirements and maybe not mention the failures in the past...

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

Right. Yup.

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

...but this would be obvious to the audience who, you know, what we’re talking about. And these are the kind of things that come out in the presentation to the committees and we can go deep on it there.

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

Right.

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

But, that’s a good point to capture.

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

This is Larry Ga...

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

You end up with...go ahead Larry.

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

I think this first bullet of recommendations is probably going to be the most important thing that anybody reads when they take a look at this is they’re going to go right to the recommendations, they’re going to read the first one and they’re going to set an opinion. And so it almost feels like we ought to be mentioning here the idea that we want to be leveraging existing work as much as possible, so that this is an evolution and not a revolution.

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

So we do, in the assessment part, Larry, I think we do say something about that. But to your point, maybe they’re going to skip over that and jump right to the recommendations. I guess the thing...the balance we need to strike is how to make this clean and get the main points across.

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

Right, because I really...

Wes Rishel – Independent Consultant

This is Wes...

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

Go ahead, Wes.

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

Go ahead.

Wes Rishel – Independent Consultant

I thought someone who had been speaking was continuing, so I stopped. I...to a certain extent, I think we're after a bit of a clean sweep here. I mean, I don't want to suggest that it's a virtue to throw away existing standards and certainly wouldn't want us to go away from code sets that we know and so forth. But, we are talking about sort of different operational modes and transcending difficulties with existing standards and I wouldn't want to leave...to let someone so inclined to draw the impression that we were arguing for just doing what we've been doing a little better.

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

Well, I think...I agree that the end result will appear as if it's revolutionary, but I think the way to get there has to be through an evolutionary process and...because you can't just drop what we've already got and that there...because there may be value...there are different ways to skin the cat. You could just throw away everything you did and throw in an entirely new system, but we're likely to be more successful if we evolve our current system into what we need to get...we need to get to.

Wes Rishel – Independent Consultant

Putting my card down face up, I think many would regard going away from the existing IHE-based standards for what was once called NwHIN as throwing away what's already been done and I believe in that respect, what's already been done is based on communication protocols and an operating model, in terms of what constitutes a query and what constitutes a unit of data that is not in line with the recommendations of the JASON Report. The same people would regard FHIR as being a total replacement and OAuth 2.0 and whatever other standards might ultimately be chosen, because they haven't been used so far. And I would hate to have those options ruled out a priori by a statement about continuity with the past.

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

Yeah, this is Arien. I think the word incremental might better cover the intent. I don't...I would agree with Larry that I don't think anybody is calling for flipping on a new network tomorrow and it will all work. I agree with Wes that the term evolution not revolution could be interpreted as well let's keep using all the same stuff for a long while because it's working and don't mess with it. And I think what we're talking about is an incremental transition to the coordinated architecture that we're talking about.

Wes Rishel – Independent Consultant

Well Arien, I think incremental would raise the same concern that I've stated...

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

Umm.

Wes Rishel – Independent Consultant

...but I think that talk about an approach that leverages existing work would sort of convey the notion of don't throw it all away and start over and yet show the degrees of freedom that we think the ultimate architecture, the developers of the ultimate architecture should have.

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

I'd be fine with that.

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

Right.

Wes Rishel – Independent Consultant

Yeah, okay.

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

Can I...this is Micky, can I suggest that we keep going and I'll make a note here for us to revisit this question of, are the recommendations capturing the spirit of this discussion of incremental versus evolutionary versus moving to a new paradigm. But, I want to make sure that we get to sort of the meat of this.

Wes Rishel – Independent Consultant

Works for me.

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

Yeah and this David, just to put my cards on the table, I'm thinking of this as a formulation of a new architecture that leverages the public API under some new constraints for how we govern and implement that. And it is a new activity that does not cause older activity to stop, that activity still goes on and serves whatever purpose it needs to serve. When this new coordinated architecture is in place, however, it may be a superset of the older activity and people may choose to switch over and achieve certain things with the newer architecture that they currently do with older approaches.

So, it is a fresh start, but it is not a stopping point for the old stuff, the old stuff continues until it's no longer relevant, until it's no longer...until there's a better way to solve it. So, the key notion here is this public API which includes much of what's in the current approaches, it includes document query just like XDS, but includes a lot more. So it's a new architecture that will evolve and become good enough at some point that people start to use it and it's not really a comment one way or the other around the older architecture. That's just how I'm thinking of it, now...

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

Right.

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

...there will be parallel existence, but we have that all the time in healthcare, so, anyway.

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

I'm sorry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

It's Larry Wolf...

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

No, no, it's a great point. Yup.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I wanted to quick jump in with, I think we need address two really powerful voices that are out there and they're embedded in our conversation, so I don't think this is new for any of us. One is a sense of urgency and frustration from the people who feel like what we have doesn't work. And a second, from mostly the people who have put in place the things we have today, saying there's a tremendous resource here of what we've already built and we're making great progress on the things that you guys really want and we want also to bring this forward. And I think we need to acknowledge both of those voices in what we respond to, right at the beginning.

And I'm also hearing that in addition to sort of like those key points that are in the key concepts that are in the glossary, that maybe we need a couple of principles up front, that also talk about some of these driving things, and again, maybe more in the slides than in the document. But I think that organize some of these trade-offs we're talking about, about building on what we have, creating some new capabilities, the kinds of new change that those will enable and that the fastest way to get from here to there is to build and evolve what we currently have. And even given the push and everybody's running as fast as they can under MU1 and MU2, it's been a painful 5 years and anything new that we propose is going to have its timeline, regardless of people's wishful thinking. So...

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

Yup. Okay, I think those are all great points, when we come back for the next round, we can sort of figure out how to capture those in a variety of structural ways as well as sort of reflect on whether we think that in looking through all the recommendations that the...sort of the spirit of what we've been talking about here is also captured. So let me move to recommendation two, which gets at some of what you were just talking about, Larry.

But sort of the second point...the second recommendation, and when David and I were thinking about the order of these, we were thinking about Larry Garber's very point which is, people are going to turn to the recommendations and they're going to start reading through them and we want to make sure that the most important ones are right up front, so that's why this one moved up to number 2. And we think it's a key point, which is to say that what we're proposing, just step back for second, what we're proposing here is rapid acceleration, you know, we're caught between...in the world of the limited, but certainly in certain cases, sort of deployed use, real operational use of an older set of standards that are functionally limited in that they don't enable data level access in the way that JASON had described as being a part of the future.

They do enable document level, but don't enable data level, not based on modern design principles, hard to implement, all of those things, we're caught in the world of those being out there and having some degree of success, but certainly not universal, and not...and then a new standard or potential standard that's not yet ready for primetime in healthcare, right? So we're caught in between here and one of the thin...under one of the stated themes here is that we need to accelerate the process of getting FHIR, as we'll discuss later, as a leading candidate to a point that it can be ready in time to meet some of the urgency that Larry Wolf has, I think, very nicely described.

So, the recommendation here is to say that Meaningful Use Stage 3 is going to be not the on...not the sole answer to that, but it is a very important part of that, because it's a very unique lever. But learning the lessons that we've learned from Meaningful Use Stage 2, the more we expand the complexity of Meaningful Use requirements, both on providers and vendors, the less capacity they have to do novel things. And so this is essentially proposing that there be sort of a bargain here, which is to say that we should, if we really care about this, we should narrow the scope of Meaningful Use Stage 3 and associated certification and focus on interoperability and reduce the breadth of the complexity of Meaningful Use requirements and in return, set a higher bar for interoperability specifically related to the development of public APIs. That's essentially what this is saying.

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

This is Arien, that voice over was excellent, the words don't exactly convey that, the words say something like we're going to focus on interoperability, to focus on interoperability in return for higher interoperability.

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

(laughing) Yeah, I'll get the transcript and...

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

I think there's a reword that needs to get done here.

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

Yup.

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

There's also a timeline consideration and if we're looking at...if this is the recommendation, we're actually doing something towards the coordinated architecture for Stage 3; we're focusing there to get that done. We need to be mindful that the Final Rule will be somewhere in the end of the first quarter or second quarter of next year, and that puts some timeline considerations, in terms of what can get done.

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

Yup. What do others think about this recommendation?

Keith Figlioli, MBA – Senior Vice President, Healthcare Informatics – Premier, Inc.

Hey, it's Keith from Premier. I agree with that point, I didn't read it that way, but I do think it should be stronger, the point that...the way you laid it out Micky. I think, again, from where we sit at Premier, if that's one of the strongest recommendations coming out of this, I think it's going to be well received. And it's very actionable, whereas some of the other stuff is not so actionable.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

And this is Gayle; I think this ought to be recommendation number 1, not recommendation number 2. I mean, this is the key to what we need to achieve and it really captures everything that needs to happen. I would put this as recommendation number 1.

Keith Figlioli, MBA – Senior Vice President, Healthcare Informatics – Premier, Inc.

And I second that. It's Keith again.

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

I'm hearing people like this recommendation. I do as well.

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

Yeah. Not the way it's written, but the way it was stated.

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

Yes, not the way it's written, but what you said.

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

The spirit of it.

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

Yeah, I think this was written after the Patriot's game and I was in a really bad mood.

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

Well, and this is David, it was lower down in the stack and I got it pulled up at least to number 2, so I'm glad we had the insight to get it that far.

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

Yup. Okay, so it sounds like we're in agreement to reword it and make it more pointed and to actually have it be the top recommendation.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

And this is Josh. I had one more question about the recommendation that's currently labeled number 2. I love what it describes, but I'm wondering if what we're proposing in recommendation number 2 is aligned with the timeframe that we're proposing in recommendation number 1, or are those just two separate things? In other words, if number...is the current recommendation number 1 the ability to achieve number 2? Or they're two separate things?

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

My view is that number 1 is part of what you need to achieve number 2, to understand what it means to set a higher bar for interoperability, how would you actually define that in a way that can be instantiated in a Meaningful Use and associated certification recommendations?

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

Okay. But the timeframe for number 1, we're talking about starting a process that would take 12 months to develop a plan doesn't really fit with a narrowed scope Meaningful Use Stage 3, which will have been totally defined by then.

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

So, well, I guess, just thinking out loud here, is it, I guess the thought in number 1 was that the first thing to do is to engage the FACAs and the working groups in taking us down one level...to one level of detail. And that that in turn would put ONC or set off a process that some more focused work and deliverable oriented work could then be started. That entire thing, the idea is that entire thing could happen within the 12 month timeframe, not that the next level of input and detail from the FACAs and the workgroups would take 12 months. I was...I mean, again, I'm just thinking out loud here. I was thinking that that's more of a couple of month process if you look at the timeline for when ONC wants inputs to its roadmap, that's all by the end of the calendar year and perhaps even a little bit sooner.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

Well I agree with that last part Micky, but the ONC roadmap doesn't seem like it's designed to support Meaningful Use Stage 3...

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

Meaningful Use, right.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

...and beyond that, maybe well beyond it.

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

Yeah, yeah, yeah. No, I think that's a good point and then Arien's point about, what's the reality of the...when the Final Rule comes out and how much input do we have into that, I think are all fair points.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah...this is Larry Wolf, I think that the whole timing issues around Meaningful Use Stage 3 are problematic, but we should acknowledge that that's there, but we want to move forward as rapidly as we can, both on the standards development, on industry initiatives and on supportive regulations. And maybe not...

Wes Rishel – Independent Consultant

But...

Larry Wolf – Health IT Strategist – Kinred Healthcare

...maybe get out of this mindset that says, until it's in the reg, we can't do it and need to start a mindset that says, the regs are going to follow behind industry best practice and they're going to formalize the burgeoning groundswell that's happening around delivering this stuff rather than becoming a regulatory floor that turns into an operational ceiling. And I sort of feel that way about a lot of what was done with MU1 and what I'm hearing about MU2.

Wes Rishel – Independent Consultant

This is Wes, I think what Larry just said was incredibly articulate and right on point. And my only concern is that we...that the second part, which we're trying to avoid happening, is all too true. That is, what about...what can ONC do that would prevent the primary implementers, mainly vendors, to focus all their resources on achieving absolute nominal certification for Meaningful Use Stage 3 and draw resources away from doing what they have some...only some de...I mean, some demand for. I guess the best outcome is that a bunch of big buyers who are still in the contracting stage demand vendors to work with these evolving new standards, otherwise I think we're in a position where we can say all we want about how Meaningful Use Stage 3...Meaningful Use in general, creates this ceiling that becomes a floor, but we won't actually have any effect in changing that.

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

This is Arien, in response to Wes' point. The largest contracting process for which ONC has any influence is the DHMSM procurement and to the extent that there's any direct federal authority here, it would be DHMSM based. So, it makes me wonder whether we should have a recommendation that ONC collaborate with other federal agencies to incorporate the coordinated architecture into operational and procurement activities.

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

So that was a JASON recommendation...

Wes Rishel – Independent Consultant

But...

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

...in particular.

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

Yup.

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

I'm also...

Wes Rishel – Independent Consultant

Would you spell out that acronym Arien?

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

DHMSM, D-H-M-S-M, S-U-M, some...I don't know, it's a...I actually have no idea what it stands for, Defense Management...

Wes Rishel – Independent Consultant

It's defense EHR, DoD...

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

I know what it stands for...

Wes Rishel – Independent Consultant

...EHR procurement.

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

...procurement.

Wes Rishel – Independent Consultant

Right, yeah, okay. Thank you.

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

Defense Health Medical Management System.

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

Yes, thank you.

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

Right.

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

Yeah, I think that point about recommending the incorporation into the federal procurement is a good one that was an actual JASON recommendation and somehow we've dropped that out along the way.

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

Right. Yeah...

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

The only concern I have is from past experience that entanglement with the federal process can slow you down as much as it enables a powerful market player. So...

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

Yeah, the...

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

...double-edge...

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

...sorry, the counterbalance to that...this is Arien, is that based on the timeline of procurement activities, you want to set those activities up facing the right direction directionally because you're otherwise it's really hard to change very quickly, just given the scale you're talking about.

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

Right.

Wes Rishel – Independent Consultant

Yeah, I think...

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

And you also don't want the federal requirement to set the floor requirements.

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

Correct. Yup.

Wes Rishel – Independent Consultant

I think we should...

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

Be aware that all of those proposals are in within the next month.

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

Yeah, I was going to say, the timeline is pretty much over, I'm afraid.

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

Setting the ceiling now would be...

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

It's not over in the sense that there are of value, there were proposals that are coming out, but there are also evaluatory processes. It's not as if it's already procured and live and operational.

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

No, the award would be a year from now in June...

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

That's right.

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

...and...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

What Arien is saying is that it's not over til the fat contractor sings.

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

Speaking as one such?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Right. So, this is Andy Wiesenthal. My comment there is that I think actually here I support Arien's thinking is, I don't think that taking advantage of ONCs centrality in the DHMSM process would be a drag, I think it would be a push. There are lots of things that can slow the military health system down, but their attention is fully focused, they have a window of opportunity for their budget and they need for these standards to be in place in order to make Tricare Work. So, they are interested and this is a good lever for ONC rather than a potential drag anchor.

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

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

Yeah, so...

Wes Rishel – Independent Consultant

I...go ahead.

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

This is David, just David. The point that we made in our early round of presentations that I think everyone now understands pretty well is that ONC has the power to control what gets certified, and we'll talk about that in one of our later recommendations. Those certifications can then be incorporated into many different federal programs or non-federal for that matter, but we could approach it through the notion that as a lever arm of requiring certification of some of the public APIs and the core data services could be made a contingent requirement for the DHMSM award, for example, amongst other things, which would be a way to connect the dots, if you would.

Wes Rishel – Independent Consultant

This is Wes; I missed the pre-read version of this for some reason, so I'm just trying to scan through it now. But, this document should, if it does not, make the point about this unfortunate timing. I mean, it should sort of somewhere make an explicit point that we need to sort of disrupt the ongoing Great Mandela of standards here to allow for this new approach to be introduced and so that people understand the necessity of doing the kind of things we talked about as far as refocusing Stage 3 or dealing with DHMSM or etcetera.

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

I th...this is Micky, I think that's a great point Wes, to make that point somewhere in here and just reflecting on, and I think I said this at the previous meeting, if you look at the PCAST Report, one of the things that PCAST says is...the PCAST Report says is, gee, there are some good ideas in here, but you know what, it's really too late for Stage 2, so, guess we can't do any of them. And we don't want to be caught in that same situation.

Wes Rishel – Independent Consultant

Funny, one more stage, one more report, how about that?

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

Right.

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

Yeah and the other...this is David. The other side effect of recommendation number 2, which we'll elevate to a higher point, is that freeing up resources for sort of needless, over-specified MU3 is good for the vendor community to go work on these other things, even if the timing doesn't align with MU3. So in other words, the drive for better interoperability is going to come mostly from the markets and the vendors would love to respond to those markets, but they're too busy getting ready for Meaningful Use requirements.

So, there doesn't have to be a tight coupling between the timelines, it's a good thing to free up those resources to let the vendors respond to market demand towards greater interoperability, using the public API, even if it doesn't line up with MU3 itself. Because that's the CMS Incentive Program and this is the certification side of the house. So, I think it's consistent with...I mean, I think maybe we want to call that out, it is unfortunate timing, but even if they don't line up, it's a good thing to free up resources to work on the more important stuff, even if it's unaligned and...

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

Right. I think that's right and the de-linking of the certification from Meaningful Use I think is an important thing to make sure that we're clear on...

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

Yeah.

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

...and how that could be an important piece here.

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

So we should probably keep it moving so can we go to the next one.

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

Yup.

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

So, let's do number 3. I think we're going to discover that there is some wording...we need to reword this and tweak it a little bit, but hopefully it will capture the essence. So this is sort of where we dive into, what do we mean by coordinated architecture and the point is in opposition to a top-down architecture. So it's an architecture that is we'll define in a minute, loosely-coupled and coordinated at the high level, but is not defined as a monolithic, top-down architecture. And, I mean, I think that just goes totally without saying, but we have to say it and maybe we need to say it stronger than the way those words are.

So, we over and over again in the document, reiterate that the pursuit of interoperability should tap into the dynamism of the market, in particular focusing on enabling more innovation around market needs and clinical interoperability. We admit, in number 2 or we call out in number 2 that this may be referenced to the discussion we had a few minutes ago, that there are already functioning and newly emerging data sharing networks in the market today, that utilize different architectures and standards for specific business cases, and there is a lot of heterogeneity out there. With the adoption and exposure of the public API, these networks would become upper case Data-Sharing Networks, as part of the coordinated architecture.

Now maybe this is...maybe this bullet point 2 is where we can elaborate a little deeper on the notion of leveraging existing networks. So the thought here is that the existing networks, when they incorporate the public API would become part of this coordinated architecture, but doesn't imply they would go away, they just would add these new capabilities, so any approach to a nationwide architecture needs to be flexible to these differences and responsive to future markets for interoperability. The centrally coordinated architecture would provide direction and guidance to facilitate and encourage cross-data-sharing networks, standards-based interoperability, loose coupling at the network level for an agreed upon set of core functions without attempting to bind each data-sharing network to a single architectural approach. That's...I think we may need to rework that, but hopefully the spirit of that is...re-word that, but the spirit of that is hopefully clear.

The coordinated architecture would use Internet-style patterns and building blocks, as described in the technical appendix. The loosely coupled architecture applies at the EHR or data container level as well as at the data-sharing network level. In a world of ubiquity...ubiquitously available public APIs, key role played by the data-sharing networks will thus not be so much technical as to efficiently facilitate legal and business arrangements focused on high value use cases defined by their customers.

One little comment here that's obvious...may not be obvious is that the technical appendix contains a lot of the details about Internet pattern, building blocks, loosely coupled, RESTful architectural style. We moved some of those technical details to the appendix to avoid the distraction in these high level bullet points. I am not sure on this call we'll have a chance to go and work our way through those, but certainly I would hope each of you who cares about the technical details to read that and send us feedback on it. But anyway, let me stop with the notion of introducing a coordinated architecture and get your comments. There may be a better phrase, coordinated architecture is what came into my head, I think we had used the language, a centrally coordinated architecture and I just grabbed the coordinated and architecture words and certainly open to a better term if there is one.

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

I...this is Arien; I really like the term coordinated architecture. There is something that I think is missing here, which is that in a coordinated architecture, and I'm thinking of the narrow waist of the hourglass, the Internet hourglass, there are some things that everybody needs to do the same way in the middle. There is heterogeneity at the top, that is, there are lots of broad uses of things that are done in the middle and there's heterogeneity at the bottom. That is, there are lots of ways of going about implementing the core capabilities. And I think that's in here, but I'm not sure it's explicitly called out that there would be some function that each data-sharing network would be expected to do and provide as core services.

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

Yeah Arien, this is David. That's a good point, that Internet hourglass discussion is actually mentioned in the appendix, but the...what might be missing here is, in terms of a forward reference, is the notion here is that the coordinated architecture would require the implementation of the public API. And the public API would be that set of core services that's the narrow waist of the hourglass...

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

Yeah, it would depend on what's in the public...

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

(Indiscernible)

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

That's right, it depends on what's in the public API, but there are cross-cutting concerns like identity, authoriz...this is, I'm repeating my previous comment because I still don't see it here. There are cross-cutting concerns like identity, authorization, authentication, patient's identity matching that may need to be provided by the networks.

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

Yeah, so, let's...I think that's a good...we need to revisit the cross-cutting concerns when we're done and see if we inadequately address that or if we need to move it around. I think that's a good point. Again, trying to, what's the equivalent in the Internet world of DNS, maybe?

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

That's right.

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

If you have individual servers implementing their HTTP and their HDML according to the standards, but somebody runs the DNS and the Internet would not work very well without it. Okay, so let me go ahead and do number 4, because I think it flows from the high levelness of coordinated architecture. And this one is a lot of words, again.

The coordinated architecture would be based on the use of a public API that can enable data and document level access to EHR-based information in accordance with modern interoperability design principles and patterns. I think we probably need to word that maybe EHR is the wrong phrase to use there. But take it for what it is at the moment.

The public API comprises two components, an implementation of certain "technical standards" and an agreement to meet certain "obligations" governing public access to the API. The APIs, and that's the core notion of what we mean by a public API as opposed to a standards-based API. The notion of public brings in some obligations around access to the API. The API should enable access to both atomic codified data as well as structured and unstructured clinical documents, it's a point that we've come back to over and over again, maybe it's more detail than it needs to be at this point, but I think people will ask about it.

Bullet...sub-bullet point 1 there is JASON and others have noted that automatically generated documents such as some C-CDAs can be unwieldy, even though they may contain useful, structured data. Nonetheless the narrative content is extremely important clinically, so we want us to not forget that, the narrative should not be lost if you focus on discrete data elements. There's no currently accepted healthcare industry API that provides...widely accepted API that provides data level access and the current exchange standards such as XDS and the XCA wrapper allow access to structured and unstructured documents, but not to individual data elements. The JTF believes that FHIR and FHIR profiles are currently the best candidate API approach to data level and document level access to healthcare.

What makes an API a public API is a set of conventions defining public access. A public API does not imply that the data is exposed without regards to privacy and security. An API provides the technical means for data level and document level access to EHR; however, there are legal and business considerations that must be addressed for any given provider and/or vendor would allow another party to use the API to access information. And what is public in the public API is that the means for interfacing to it are uniformly available, based on non-proprietary standards, tested for conformance to such standards by trusted third parties, and that there are well-defined, fairly-applied business and legal frameworks for using the API.

I think we could shorten this point, but what do people think about the core notions in it?

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

So this is Larry Garber, one of the...you know, the other Larry. One of the concerns I have is that we are very EHR-focused in this and I think about important information sitting at the health plans and pharmacies, which may not be classically called electronic health records, yet the exchange of information is particularly important and we should accommodate that. This also gets into the prior authorization and the rules for prior authorization, our networks should be able to accommodate getting those rules and I guess I want to make sure that we don't narrow it so much by constantly saying EHRs.

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

That's a good...

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

This is Arien, I heartily endorse Larry's comment and I would note that the HITECH legislation uses the term, oh, now I'm going to forget it, healthcare interoperability infrastructure and interoperable healthcare info...so, there's a notion of the healthcare information infrastructure that is broader than the EHR.

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

Yup, that's great.

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

Yeah and we...in our previous document we actually used the term clinical and financial systems, which is, I think, broader than...certainly broader than EHR-based information, so, I don't know how we just...that's an edit that we missed. So...

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

Yeah, can...

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

...we'll change that for sure. That's a good point.

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

Right, so we agree on healthcare information infrastructure in general? I like that term.

Wes Rishel – Independent Consultant

I have a concern that some people would read that term as everything but the operational systems such as the EHRs, whereas here...

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

Oh.

Wes Rishel – Independent Consultant

...I think the idea is imposing a requirement and providing a mechanism to the operational systems. So I like operational clinical...operational healthcare...operational, clinical and financial systems.

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

Okay.

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

Yeah, we didn't...we certainly didn't get any pushback around that from earlier using that language in the first presentation.

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

Right.

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

We broadened it from the JASONS, the JASONS were really somewhat focused on the legacy EHRs and really only on their TDR capability and so we've already broadened it and I think that's...maybe we need...we certainly should update this to reflect that broadening.

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

Yup.

Wes Rishel – Independent Consultant

Not to...

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

Micky, I think we can shorten a couple of these bullet points and capture them. I like the last of the three major bullet points, what makes an API a public API, maybe move that one up and then the access to atomic and codified data as well as structured and unstructured stuff, that may belong somewhere else, just as a note to our editing process.

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

Yeah.

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

The point here is to sort of say what does it mean to be public, or at least introduce the notion that as opposed to other implementations of APIs, this one carries with it a certain obligation to document it, test it, certify it and expose it, according to some form of reasonable and customary approaches. I toyed, Arien, with the notion of introducing that RAND licensing language into here, but I didn't follow through on that, I don't know if there's any value in doing that.

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

Yeah, I think that would maybe be too geeky.

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

This is the other Larry again. One of the issues, as I look at this, part of the technical standards I assume includes vocabulary standards, SNOMED, LOINC, whatever. And part of what makes it public is that not only are they not proprietary, but I would have assumed that they are free of charge if something is public, and that may not necessarily be the case, such as CPT. So, I wonder if...how we handle that.

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

We toss that one over the fence for somebody else. Yeah, that's a great question. We have...we do not have any explicit statement in here about things being free. We do acknowledge that there are licensing considerations and as much on the legal, what are you allowed to do with this, you must prove that you are an appropriate organization to be using this, you must be certified to not break it and so forth and so on, that we just acknowledge that those concerns have to be accounted for. But we don't have an explicit statement about cost of the use of the APIs or cost of any of the nomenclatures that might be referenced in the profiles. One would hope that the folks that design the core data profiles selects nomenclatures that are free, but we don't say that explicitly. And then there are a few that are mandated for billing that are a government guaranteed monopoly effectively, so not much you can do about it. We won't mention who.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So...

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

Maybe use something like, to the extent possible or to the extent reasonable.

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

Yeah and we could put that in the technical details, I mean, we have not said much about, I don't think we've mentioned vocabulary anywhere, really, other than implied that it's a part of what a profile does is specify the value sets.

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

Yeah, but there is a key point that's coming out here which is that a public API does not require licensed access. That doesn't mean that it's free to access, but it doesn't require intellectual property or other rights management to access or implement. And I think that's a core principle, there may be specific exceptions in the case of government mandated terminology sets that reasonably must be licensed, but I do think that point is a core principle that needs to be called out.

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

So Arien, would you...this is David, would you restate that IP licensing thought, how would you express that?

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

I would say a public API must be, to the extent reasonable, implementable without IP licensing.

Wes Rishel – Independent Consultant

Without IP licensing fees.

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

Without IP licensing fees, correct.

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

I like that, that's good. That's good.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, this is Larry. So I shouldn't be...the other Larry, I shouldn't be worrying about HL7 sustainability, but the SNOMED guys were pretty smart and got the US government to buy a national license. This is a really valuable resource, I don't know that I would want to throw away that opportunity to...HL7.

Wes Rishel – Independent Consultant

Well I...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, speaking as the SNOMED guy, it's not...there isn't a national license. The countries support the work of the organization, maybe it's a fine line, but once a country is a member of the IHTSDO, then all use of SNOMED CT within that country is without charge.

Larry Wolf – Health IT Strategist – Kindred Healthcare

(indiscernible)

Wes Rishel – Independent Consultant

I think that's really splitting hairs. I think if IHTSDO were to enforce its ownership, it would look an awful lot like a licensing suit. The...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

But it does enforce its ownership, Wes.

Wes Rishel – Independent Consultant

Right. Okay, so then I think that the distinction is pretty fine. I was going to suggest modifying our language to say, end users...I forget the wording we chose, but to say that there should...end users should not have to pay licensing fees for standards so to specifically disallow the case or not worry about the case where the government has decided to fund the development of a code set or something.

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

End users and developers should not...

Wes Rishel – Independent Consultant

Right. Yeah.

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

Yup, I like that.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, what are you going to do with CPT? You all...but it's a...that statement will be taken very badly by the people who own that IP.

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

Yeah, one of whom is going to be on the governing committee of the Standards Committee.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

I mean, we could say it if we all believe it, but that will be viewed as some form of socialism.

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

Well, this is Arien...

Larry Wolf – Health IT Strategist – Kindred Healthcare

As opposed to have never been...

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

...all that being said, I think there is a success pattern that we see in APIs in the Internet and I think there's a failure pattern that we see, and I do think we have an obligation of noting that the notion of a public API requires adherence to some of these success patterns.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Um hmm. I think we can make those observations...

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

Yup.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

...but unless we're prepared to be in a big fight about the use of CPT, we need to stay away from declarative language...unfortunately stay away from declarative language that says what we just said. I actually agree with the language...this is Andy Wiesenthal, by the way, for the record, I agree with the language. But, I don't think we're...I mean, we are just going to torpedo the whole document if we say something like that.

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

And this is Arien, that's why I suggested the words, to the extent reasonable or the extent possible, understanding that there may be large medical societies and others that...where that may not be possible.

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

Right.

Wes Rishel – Independent Consultant

Well I think...

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

Maybe we should leave it at that, because we're...also, this is a principle and we can say to the greatest extent possible or something like that.

Wes Rishel – Independent Consultant

Well I don't think we've addressed Andy's comment if we say to the extent possible. I mean, his specific suggestion was to, if I understood him properly, was to not put explicit language like this at this level in the document, but to raise the issue at a subordinate level. And he gave a good reason why and I think we need to just face this question squarely and I find what he says reasonably...mostly credible. I don't know the specifics, but it's certainly I'm tending to want to do what Andy said as much as I hate to.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well thanks for that compliment, Wes.

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

We'll call you mostly credible Andy.

(laughter)

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Under duress.

Wes Rishel – Independent Consultant

Under duress.

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

So this is David. How about if...I liked Arien's success pattern of the Internet, how about if we word it something like, the JASON Task Force notes that much of the Internet success stems from the fact that end users and developers are not required to pay licensing fees and to the degree possible, the public API should be treated similarly or some such language like that.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

I think that's fine and...this is Andy, I think that gets at...it avoids a major landmine.

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

Yeah, and it...

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

Okay.

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

...raises the point in general that reducing friction for the use of the API is a huge advantage so...

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

Okay. Why don't we keep going.

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

Yeah, we should go on to...

Larry Wolf – Health IT Strategist – Kindred Healthcare

The other Larry...

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

Oh, go ahead.

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

Go ahead Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, at the risk of one more minor obstacle that at least should be acknowledged, there's an operational concern here of we're looking at organizations pushing information has a lot of control over the load on their systems, where they're opening up an API, architecting that and engineering it to be responsive and not to destroy the performance of the primary services of that system, as well as its support for this API might create its own set of obstacles. And so I wonder where we're listing sort of the business, legal and clinical concerns, that we include operational. And I know it's sort of a code phrase to talk about things like performance and loading, but...

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

Yeah, so this is David. One of the thoughts there was that access to the API would...we would not consider it irresponsible, that's a double negative, let me try again. That services that connect to the API would need to be certified that they don't abuse the API or use it in some way that impairs operational behavior of the core system. So, I think that's an idea, we may not have captured the language well, but we've...I think we all agree...we have agreed to that in the past, you can't just hook something up that breaks everything else, that doesn't work. Although there is some pressure on the vendors to make sure that the API is, in fact, efficient enough so that it doesn't break things when its used for appropriate purposes.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

So this is Josh...

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

(Indiscernible)

Larry Wolf – Health IT Strategist – Kindred Healthcare

There's also a need on the provider's side or whoever's hosting the service for them, to have actually built out the environment in a way that it can support a new class of load and it's not just about licensing someone or agreeing with someone that they're going to have permission to access your system, but you're actually able to deliver that service.

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

Yup.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

...Josh, and I just want to raise one point here because I don’t think, at least on my end, that there’s broad agreement with this idea, especially for patient-facing applications that a patient wants to choose that the App would have to be certified up front before it could connect to a network. And certainly we see with public APIs in the sense of Google and Facebook, anybody who’s a developer can register an App and connect it to one of these platforms. And there are built-in things like rate limiting and protection from denial of service attack and the platform just has to take care of that stuff to operate at the scale that it does. And certainly for patient-facing applications, I wouldn’t want us to put in a hurdle where the App had to be certified against every different network where it might want to run before a patient would have access to it.

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

Yeah, good...Josh, David, good point, the certification is an option that makes sense in some networks, but it would not...I would not posit that it’s a requirement. But I think the notion is that the public API because of the fact that it deals with very sensitive data and it’s coupled to very critical systems is not a free-for-all, that the network may choose to put some constraints on access to that public API that are consistent with respect for privacy following HIPAA if it’s inside a business associate agreement, performance considerations and so forth. But, let’s call it an optional set of constraints, it wouldn’t break the spirit of it being a public API but it does reflect that fact that these are mission-sensitive, just in critical APIs.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

So do you agree with the principle that patient’s should be able to pick the App that they want to connect to these networks?

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

Well, I would say that’s a data-sharing, network decision that may make sense for a certain approach and we wouldn’t preclude that. In other words, I don’t think we need to say that one way or the other, we just...but we do need to say that you aren’t violating the notion of it being a public API if you do have some reasonable constraints on who connects to it along the lines of respect for privacy, non-abuse of the standard, certification that you’re not breaking the standard, doing things with it that aren’t allowed and so forth. So it reserves the right that a public API could impose those constraints, but doesn’t require that you put any particular constraint. Does that make sense?

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

David, I think it does, but the way that you just used the public API, I think, in my mind at least, you may have switched in that one sentence from the API definition that we all agree on for the coordinated architecture and a specific implementation of that API that runs within a given system. The implementations might impose these kinds of certification requirements, but they’re not part of the API.

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

Yes, yes, yes. Good point, good point, I was implicitly describing an implementation of the API.

Wes Rishel – Independent Consultant

Well, I would argue that you were anticipating a constraint stated as part of the API and disallowing it and, of course, maybe for double negatives, we don't need to put them in. But, the way I understood it, the thought that you were looking to vanquish was that this API would include a requirement that all access to a public API be totally open.

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

Umm, totally unconstrained. Yeah...

Wes Rishel – Independent Consultant

Yeah.

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

...I'm banishing the idea that it would have to be unconstrained.

Wes Rishel – Independent Consultant

Right.

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

I don't know if that's one and a half negatives or something. So let's...we've registered these concerns and will revisit the language, let's move on to number 5. I think Larry or Micky, do you want me to do this one or do you want to do this one?

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

Either way, I'm happy to.

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

Okay, why don't you go, they've heard me speak for the last two.

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

Okay. Your voice is getting tired, okay, so the idea...

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

No, they're getting tired, their ears are getting tired.

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

They're getting tired, oh, I see. Let's not expose them to any more of that then. So the idea here is now we're sort of doing the going down the layers here. We started with a coordinated architecture, then public API, now we talk about sort of constraining and focusing the public API. So the public API should implement a set of rigorously defined core data services which would be selected to expose key data access functions for, this is my favorite term as David has noted, high value healthcare interoperability use cases. So the idea here is that you would have core data services which are enabled by the public API. We intentionally sort of constrain those very highly at this initial sort of period here, but the idea is that the core data services would grow over time.

So, we just note that the coordinated architecture and public APIs could take years to completely span the full range of healthcare data, as you know I think Stan Huff noted in one of our listening sessions, he threw out that it could take 10 years for that to happen. So, the idea here is, let's focus the recommendations on a narrow set of data services that we think are both high level and are feasible in the timeframe that we're talking about. So, we categorized sort of four general use cases aligned pretty closely, I think, with the uses envisioned in the JASON Report, and we put those into four buckets; clinician-to-clinician exchange, consumer access, pluggable Apps and population health and research.

And in the next set of bullets, we describe that the focus, we believe, for at least as it relates to Meaningful Use certification and the Meaningful Use process in general, should be on clinician-to-clinician exchange and consume access through tethered patient portals. And we'll go down that in a second. And that's not to say that work doesn't continue or the market doesn't continue on pluggable Apps and population health and research, but the focus as we sort of think about Meaningful Use levers ought to be highly constrained to these two use cases.

So, the idea here...I'm trying to move the...what's on the screen. So the core data services are highly specific, rigorously defined data access services. They are accompanied by data profiles, which tightly specify the required and optional data elements used by each of the services such that on-the-wire data formats, codes and value sets can be shared and understood by both sending and receiving parties. So, there's nothing conceptually that limits the amount of data that goes through a public API or the scope or the breadth of data, but the idea here is you have core data services which constrain at core data profiles which would really sort of fully specify what types of data and how the data needs to be codified for the particular use case that's enabled by the core data services.

So the core data services and the profiles sort of define and circumscribe the coupling. To the extent that we've talked about loosely coupled, here is where we're defining, here's what gets coupled. And it defines targeted interoperability for a select group of functions; again I think this is probably stuff that can be more crisply summarized. And the core data services would include access to both clinical documents, C-CDAs, discharge summaries, where the idea is that at least in the first instantiation of this, the data...the document level side is being able to access the static documents that are available today - without the expectation that you're going to sort of build documents on-the-wire. Let's say that there are static documents available that are no accessed through XCA, XDS and in other ways. So the document level side is about just accessing those because they exist, which is a part of the incremental approach here. But importantly, it also opens up access to discrete clinical data elements.

So could we scroll this up on the WebEx here? Then the core data profiles define the key data elements and codification of those elements. So again, you want to constrain this to something, I'm going to use high value again, to high value use cases and these core data profiles being very specific, but narrow so that they are implementable and feasible in the timeframes that we're talking about.

And then the last point is that we would expect that the core data services expand over time. So, you want to...it needs to be constrained, it needs to be staged, and the narrow waist is very narrow here at the beginning and expands over time.

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

This is Arien, just as a minor nit, in core data services will include access to both clinical documents, you don't want to use the term C-CDA because that's a format, you'd want to use something like referral summary, discharge summary, the actual clinical document, because I think that's what you're saying.

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

Yup. Yup.

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

This is the other Larry...Garber. On the second bullet, I think it would do a disservice to clinicians to not try to also point out administrative simplification when one of the greatest dissatisfactions that physicians have...I just read a survey of 20,000 physicians, is that...and they said that 20% of physician time is spent on things like getting prior authorization and other stuff that we consider a complete pain in the neck and totally useless, but a big burden. And so I think that we ought to include a fifth bullet that somehow reflects some sort of administrative, operational processes. I don't know the right term to use, but specifically targeting at getting things like prior authorization automated through these APIs. And it's also not clear to me that clinician-to-clinician exchange includes things like to pharmacists, to health plans, to those other...of the healthcare system.

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

Right.

Wes Rishel – Independent Consultant

This is Wes. I 100% concur with the other Larry there that being the current...the last spoken Larry, that that's very desirable. In terms of the mechanics of what we do, we're treading on the area of another FACA and regulations that are implemented entirely by CMS and I think we need to acknowledge that that exists somehow and not appear to be trying to brush over that issue. I had another point but I forgot it, I'll re-interrupt if I think of it.

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

(Indiscernible)

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

This is Arien. I would point out that we should be careful that the notion of a core service and the notion of a coordinated architecture is one where we're not defining all of the use cases up front so things like prior authorization or medical necessity checks or those...disability determinations, those kinds of activities are uses of the services, not in this model the actual core services themselves.

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

So, I'm good with that, but I think that we should at least include some sort of administrative exchange here, whether an ancillary exchange. Clinician-to-clinician doesn't include health plans and pharmacies and labs...

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

Right.

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

...and imaging centers and I think somehow we need to have a line that...one or two lines that includes those as participants.

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

Yeah.

Wes Rishel – Independent Consultant

This is Wes. I think it's really important to put the concept that Arien passed along up front in the document, that this is...the whole point of this is to be a base for services for a wide range of functionality and a few specifics, maybe selected up front. I have to say, I'm...the emphasis that I feel on this point is informed by my hearing as a rumor that a very large EHR vendor has implemented Direct in a way that it can only be used for the use cases called for in Meaningful Use Stage 2. That sort of compartmentalizing of functionality is just 100% the point that we're trying to avoid here, I think.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

So this is Josh. What if we said here that these core data services were meant to support a diverse set of use cases that could be determined downstream, but they should include things like communication among healthcare provider organizations, consumer data access and access to data within an organization through pluggable Apps?

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

This is David. Josh, I like that, and that's certainly the spirit of what we were targeting here was some way to prioritize the initial set of data services, you know, if for example, we end up using FHIR and there are 87 resources, you may not choose to expose all 87 with full read/write access to every one of them, you need some subset of that to be an effective, implementable, core set of services. And then over time, expect to add additional resources and transactions as the market demands.

And so what we were looking for here is, what business cases or use cases would prioritize the selection of the core data services and I think your...both you and Arien and all of you have clarified that we need to make it clear that we're not talking about APIs just for these use cases, but these would just be priority use cases from our deliberations on how to establish the first set of core services.

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

And this is...in number 6, you go on to say, okay, and the one we think is the highest priority is this.

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

Yeah.

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

So, that's how I think at least here in number 5, you should at least expand it a little bit to show that we are thinking beyond just the core players, that we want to also include exchange with the payers and with ancillary services.

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

Right.

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

Yeah, no, I think your point...I absolutely agree. I absolutely agree.

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

Yup.

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

I totally agree, just saying that these were listed as prioritization efforts, not inclusive...not intended to be inclusive.

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

Right.

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

Or exclusive, I'm sorry, I said that backwards. We'll capture that for sure. And I think Micky, we do have some redundancy here as well, now that we read this thing from top to bottom.

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

Yeah.

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

We can...

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

Even though we've read it 10 times, it's amazing how it appears when you look at it in this setting. Okay, shall we move on to number 6 then?

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

Yes.

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

No actually, this is Larry, I've got a couple more...this is the other Larry, again.

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

Yup.

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

So in the third bullet, the third sub-bullet, you talk about access to clinical documents and discrete data and it still, as you read that, it still feels like we're just talking about query access to this information. And I thought it might be useful to have one more sub-bullet there that says that we envision that this includes both push and pull methods of accessing data, just so that it's clear that we've got broad thinking about how this will be used.

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

This is David, that's a good point. I thought we had that in, but it may have dropped, it may be in the technical section as well, but I think reiterating it is a good idea, include read and write access to both, blah, blah, blah, something like that.

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

Yeah, I'm not sure what that...was, but yeah, I like that, both read and write, both push and pull, I think those are good to list there. The other thing that I thought, in honor of Wes being on the phone, is that this may be the section where as these are designed, they should be designed keeping in mind the need for asynchronous, bilateral cut-over so that...because that needs to be done up front, envisioning okay, so when the next version of these services and profiles are developed that they'll be developed in a way with a general structure in mind that the prior versions will still be able to send and receive with them.

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

Yeah, this is David. We have explicit language from Wes that defines that process quite elegantly in the appendix, but your point I think is maybe we should just high-level mention it up here.

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

Exactly.

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

Yeah, I...

Wes Rishel – Independent Consultant

I sent the language to David and Micky and David, who said yeah, we'll put that in the appendix and I thought significantly about posing a single bullet to go in the main line. And I finally concluded that it doesn't rise to the level of outline or skeleton that we're talking about here, at best there probably should be a recommendation at the end that says, in doing all the work outlined here, various operational requirements should be considered, and this would be one of several of them. So, at the risk of burying my own lead here, I'm suggesting that particular organization.

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

Right, and your words are in very good company in the technical appendix, Wes, so you shouldn't feel bad.

Wes Rishel – Independent Consultant

Well I just want to see that there's enough of a forward reference to the technical appendix to feel like I was...that the idea was endorsed by everybody with full knowledge rather than with having not read the last page or having not read the technical stuff. So, that's why I'm...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

And Wes, you're mostly credible, so...

Wes Rishel – Independent Consultant

Thank you, thank you...that's the best I've ever been, geez.

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

...knowing that people are only going to read the recommendations at best and are not going to read the appendix, I think it's really a core principle that's worthy of a bullet, just for the reassurance that people know that we've thought about this.

Wes Rishel – Independent Consultant

Well that's why I'm sort of suggesting a blanket recommendation with a series of bullets that abstract what's in the appendix, not...I gave...I tried to be brief and I gave them two slides. But, I do think that the notion that there are learnings from both healthcare experience and from networking in general that are critical deserves equal prominence with the kind of policy and SDO things we're talking about here, is worth of a recommendation. I just happen to think it's the last recommendation.

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

Okay.

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

Yup, yeah, why don't we take a look at that and see how that would flow and how we would do that.

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

Yeah, I certainly don't want people to not read our technical appendix actually hurts.

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

David wouldn't have agreed to...

Wes Rishel – Independent Consultant

Hey...technical appendix.

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

...my moving that stuff...David wouldn't have agreed to my pushing all the stuff into the appendix if he thought no one was going to read it.

Wes Rishel – Independent Consultant

A lot in the executive summary.

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

That's really the most important part of the document, please.

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

Yeah.

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

Exactly.

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

Yeah, let the record reflect that that was Micky's decision, not mine.

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

I was going to say, all of you don't tell David that no one's going to read the appendix, that's how I won that argument.

Wes Rishel – Independent Consultant

I think there's a Big Bang Theory episode due about here.

(laughter)

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

Okay, any other thoughts on recommendation 5 here? Okay, why don't we scroll up then to the next one. And let's see, do you want to do this one David and I can do the last one, or...

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

Sure. I think we've covered a lot of this, some of this is redundant with number 5 and we'll simplify the language here, but...

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

Yup.

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

...the first coordinated architecture uses of the public API, and maybe I'll say should prioritize, data sharing networks that promote EHR-to-EHR interchange. We'll broaden that, we'll say clinical and financial system interchange and consumer access to core data services via patient portals. Clinician-to-clinician to be expanded to, we'll come up with better words there, is a top priority to support care improvement and is the foundation for all other interoperability. The use of the public API will expand on current document-centric capabilities as was recommended by JASON.

Consumer access to discrete clinical data via patient portals is a natural extension of the current document-centric view, download and transmit and Blue Button patient portal functions. Consumer-mediated authentication and authorization has the advantage that it does not require development of novel trust frameworks. And then we...this is a sub-bullet that formatting got mixed up on, there's a growing and active community of entrepreneurial developers in the mHealth and consumer space who are not constrained by legacy software issues and would be...could be leading drivers of real-world experimentation and technical and ecosystem maturation, and maybe also put innovation.

And then the final bullet point, JTF expects that core data services will also be used to support pluggable Apps as well as new ways to access EHR data for population health and researchers. This work can proceed in parallel, but not necessarily as part of Meaningful Use or other incentive programs.

So this is a prioritization bullet and some of it was touched on before and we, Micky and I were trying to capture in our last call, near the end of the call, Micky proposed these...this basic prioritization and we got, we think, pretty good feedback from the group. But now that you see it written down, does it still feel right as the highest priority, assuming that we expand clinician to be...terms.

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

This is Arien, I very much endorse this. I do think we should repeat the language about that the intent is not to stovepipe use cases, but that the core services should be developed such that these services are a natural use of the core services.

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

I agree, that's good.

Larry Wolf – Health IT Strategist – Kindred Healthcare

It's the other Larry, Larry Wolf and so there's some great irony here and I'm going to suggest that we expand the notion of patient portal and talk about patient access.

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

Yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I know at least one big health system is very proud of their mobile App that allows people to access their information without having to go to the portal and even if we're talking about APIs, I don't think we should focus on the portal. We can acknowledge portals, we can acknowledge view, download and transmit, but I think we should also acknowledge that there's already been work to build Apps based on vendor APIs and we encourage the expansion of that.

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

Excellent point, this is David. The portal notion is really portal account notion, and we should clarify that, absolutely agree. The notion is that if you have access to a portal with this API, you would have access to raw data, you wouldn't have to go through the portal, but you could leverage your portal account...authorization...

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

If you have access, that's right. If you have access to view, download and transmit to your own record, then you...

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

...you have access to...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, I don't think...I think the issue for this isn't the sort of healthcare provider's offering these Apps is to the user they don't have a portal account, they have an App account, they have a healthcare provider account. They're not going...

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

Well, they have...

Larry Wolf – Health IT Strategist – Kindred Healthcare

...to the portal to download data, they're running it through an App.

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

No, absolutely, but they, in order to log in and authenticate themselves against the EHR that's exposing their data, they need an account, that's the...right here.

Larry Wolf – Health IT Strategist – Kindred Healthcare

They'd need an account, they do need an account, I agree, they need an account.

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

That's what we...your clarification will get...

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm sensitive to the word portal...

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

Yeah. That makes...

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

Totally...

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

It's about the account, yup.

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

Totally agree, you're right, Larry.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

This is Josh, I'm glad that we got such quick agreement on that point because I wanted to raise a similar one, which is just the way this is worded, it sounds a little bit like we might think...we might be describing core data services as a better way to build a portal. I want to make it clear that we're not building portals on top of these services, we're exposing the services, right to patients and their Apps.

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

Agree.

Wes Rishel – Independent Consultant

Are we not not building portals?

Larry Wolf – Health IT Strategist – Kindred Healthcare

...might build portals on top of it, yeah.

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

That's right, you may well not implement these services as literally into the portal, but you will reuse the patient access and account...you will reuse the patient account that gives them access to their record.

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

Right.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

Yup, I think if you capture that that would be...

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

As provisioned by the EHR, or as provisioned by the provider who's responsible for the data and the win here is that that does not require the existence of a new national network of trusted patient identity, etcetera.

Larry Wolf – Health IT Strategist – Kindred Healthcare

That's correct.

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

As fun as that would be.

Larry Wolf – Health IT Strategist – Kindred Healthcare

It does not require a national patient ID either.

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

Right.

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

It doesn't, absolutely does not.

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

So, as provisioned by the data holder or something like that to take into account that there are payers and others.

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

Yup, yup, yup, that's a good way to express it.

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

Okay, all right.

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

Why don't you go to the next one, we got that one done quick. And we're 12 minutes away from termination here, so...

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

Okay...

Wes Rishel – Independent Consultant

How technical is that?

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

This one gets specifically at some recommendations related to the HITECH levers, specifically Meaningful Use Stage 3, the attestation requirements and the...or the behavioral requirements as well as the associated certification. And it's sort of getting at how can we orchestrate those levers in a way that accelerates the adoption of public APIs and the whole concept of the coordinated architecture. So there are three levers here.

So the first is ONC requiring that CEHRT include certification...I've jumped down, sorry, to the second main bullet, just to get us through because I think there's some redundancy in there. The first bullet is ONC requirement that CEHRT include certification of the core services of the public API. And the idea in that second sentence there, in a manner that accommodates more rapid incorporation of the evolution of core services. I think one of the points and the concerns that David has had is just that we don't want that to be a snapshot in time certification, that these things evolve and you want the certification to be able to sort of accommodate those evolutions as well.

The second is that ONC and CMS should require that vendors grant third-party access to public APIs based on agreed upon business and legal conventions. Here the idea is now, all right, so we've got the public APIs and the core services as a part of CEHRT, but you need the vendors and the providers or the payers, you know, whoever is implementing that technology, to both not impose barriers so the data or the documents are not exposed under a reasonable set of terms of sort of the legal, policy, standard business terms. But, and that's what those next two bullet points get at, that you want to stop...you want to prevent the vendors from denying third-party access for unreasonable reasons. And then you also want to use your CMS incentive levers to essentially say to healthcare organizations that you also under a reasonable set of conditions, shouldn't block access to the public API.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, it's Larry Wolf, let me jump in with a comment about a message I seem to be hearing from ONC around Meaningful Use and other levers. And that message seems to be that they fully expect that there will be other programmatic drivers for certification beyond Meaningful Use and I wonder if it is too soon to actually think about opening up our language, talk more broadly about certification programs and not couple it specifically to Meaningful Use?

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

I think that's a...

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

...yeah, that was our...

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

Go ahead, David. Yup.

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

I was just going to say, that was our intent, we should look at the language because absolutely the notion is multiple drivers, not just Meaningful Use. Maybe we don't actually say that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, I'm thinking we have a reflex that we've been talking in the MU stages for so long that I think it just permeates what we're saying and I got a reminder yesterday of ONC is trying to be as clear as they can that that's not the only thing they're focusing on.

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

Yup. Yeah, I agree, we will try to capture that if it's not there. I think maybe we don't express it very clearly.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I've got a related concern. I don't know how it shows up in here, and this might be the place where it shows up and it's about ceilings and floors. So when Meaningful Use 1 was being put together, there was a lot of discussion about that what went in to the requirements and what went into certification was really intended as a floor, but in many ways, it's become the ceiling, in some ways pretty ridiculously so.

And my sense is that successful standards in the marketplace, you know, the hourglass example, the standard really does become a floor, it's the minimum necessary to then enable a whole suite of activities. And I sort of feel like we need to remind people broadly that the certification process and the use of this information is really intended to be a floor of enabling capabilities and not a ceiling to check the box and move on to the next thing. And I don't know how to communicate that and how to make it operational, but it feels like one of the traps that's inadvertently happened with a lot of the MU program and certification requirements.

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

This is David. I think that's a great point. The hope is that a well thought out, roughly orthogonal API is sort of by definition a floor that enables a lot of clever uses. So unlike some of the other standards that we've used in the past, which were very purpose-specific and highly focused and constrained like say XDS which does one thing reasonably well. An API enables...an API of core services, core data services gets and puts against the core resources of healthcare, patient labs, meds, vital signs, orders, etcetera enables an infinite variety of use cases. That's the whole hope of this approach, that's why this is different from what we've done in the past with use case specific APIs. So I think we have to capture the spirit of that somewhere, maybe that's in the executive summary or something. So that's how I feel about it, I hope that's consistent with others.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I think that was well said, David.

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

Yup, yup, I agree. Are there any other thoughts on this one because we just have one more and we're running out of time, but it would be great to just quickly cover it and then maybe we can pick it up again in the next call or take offline comments on it.

Okay, so this is the bullet that addresses, I hesitate to use the word, but governance in some form. And so the idea here is actually to not have...a recommendation to not have out of the gate sort of governance with a capital "G" from the federal government. The idea here is that ONC should aggressively monitor the progress of exchange across data sharing networks, really building on the point that David just made, the conversation with David and Larry, the other Larry, whoever the other is, that the idea of the APIs being not sort of use specific but much more open and available and accessible for a variety of purposes, ought to enable sort of a flourishing of data sharing networks in a way that could have much greater progress and much greater coalescing around a set of uses, use cases and standards that hasn't happened up until now. And so we ought to sort of let that unfold before we assume a priori that you need a top-down governance of it.

So the idea here is to say, ONC should aggressively monitor the progress of exchange across data sharing networks as they develop. And then consider an incremental range of interventions to accelerate cross DSN exchange if the market does not enable such exchange on its own. Right, we've all had the experience, we know what happened with Direct, so we want to I think address that up front and say, those are real issues and they're real market issues and so we don't want to be blind to the experience that we've had there. On the other hand, we don't want to sort of overcompensate on the other side by saying it needs to be sort of top-down in a way that we think would really stifle progress and stifle innovation given where the market is and the approach that we're taking here.

So, let me just jump down to the third bullet point, the first two are really about explaining that the...so the idea here would be, start with aggressive monitoring and then in the event that the market doesn't organize itself, there's sort of a series of escalating interventions that ONC, the federal government at large could consider, perhaps a more assertive convening function to convene data sharing networks to help catalyze development of industry-based governance mechanisms. To develop additional data services for cross-network bridging, some of the things that Arien was describing at the very beginning of the call as essential services or something like that. Perhaps those are some of the key catalyzers that would need to be put in place that would help create the kind of coordinated architecture we're talking about. And then, well, I guess those are sort of the two points there.

And then finally, incentives, direct incentives for DSN activities or perhaps direct regulation of DSN activities. But those should really be at the end of the sort of the staircase here, but allowing the market to sort of organize itself and take accountability for this first and then seeing what happens.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

This is Gayle. I'd like...think of this one.

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

Yup.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

This gets really into the policy arena and with privacy and security being key in a lot of what happens at this level and authentication and authorization also play a key role. So, I think there may be some basic principles that need to be established first and I think that might...there may need to be some guidance or at least establishment of best practices. And I'd like to see that moved forward, otherwise you're going to wind up with states stepping in and setting some rules that may hinder interoperability across state lines. So, there's a little bit of a problem if you just do total laissez faire and let the market develop these. So I'm a little reluctant to just say total hands off at this point. You need some understanding of some basic ground rules to start with.

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

This is the other Larry, I agree with that. I was a little bit concerned just to put this totally on the back end and say, let's just let this ride for a while and if it fails, then government will step in. I think during the design, it may come out that there are certain things that really should be done proactively and so I think if you put a little fuzzy language in here, that might be better. Because, for instance, a national provider directory is not an unreasonable thing to expect the government to pull off or something like that, and may be of incredible value in enabling this architecture. And so I wouldn't want to say, it has to be after everything else has failed.

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

Right. So two great points there, one is that for some of the things, just going backward. Larry, to your point, some of those things may...I think that's a great point, they may make sense on their own and you may do that right away for reasons that aren't directly related to this, but also for reasons that would help to sort of have the industry coalescing around this idea.

And Gayle, I think your point is about just sort of a set of principles first and foremost or sort of guidance. I know at the pol...at the last Policy Committee meeting, I think there was a little bit of conversation about is there sort of a set of HIE principles or exchange principles or Bill of Rights I think was the term that someone had used, that perhaps could be sort of formalized through some kind of rulemaking process that again isn't regulatory in nature, but is sort of official guidance, in a way.

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

And I...this is Gayle again, I think it is key that we take a strong stand on that and we say that there does need to be some framework around this, at least in a way of guiding principles and then there needs to be discussion on that. The Governance Workgroup I'm sure is going to present some of that, but that needs to be part of what we're discussing as well. So, maybe we need to wait to hear from them, but I just have great fear that if you leave this totally laissez faire, we're not going to have the public trust, that's going to be essential for this to move forward.

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

Micky and David, this is Michelle. I just want to check in on time.

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

Yup, you mean we're out of it?

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

Yes.

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

Yes.

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

Yeah, we're out of it.

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

Is that the check-in you want to do? Okay, we'll certainly take more comments offline. We really appreciate everyone sticking with us through this...through the entire call, I know it's been very meaty and dense, so th...and then it was a terrific discussion so I want to thank everyone for that.

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

Indeed. Public comments maybe?

Public Comment

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

Yes please. Operator, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

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

We have no public comment, so thank you everyone and have a wonderful rest of the day.

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

Great. Thank you.

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

Thank you, Michelle. Thanks everybody, great discussion.

Wes Rishel – Independent Consultant

Good bye.

Public Comment Received During the Meeting

1. For many use cases, custom form-based structured datasets are required. FHIR does not yet address the management (e.g., querying) of form-based structured-data through an API mechanism. This is a fundamental need that is not addressed in the current report. I propose adding a specific recommendation to support the management of forms-based structured data. The IHE/ONC SDC Profile partially addresses this using SOAP, but much more work is needed to make this work with FHIR.