



Joint HIT Policy and Standards Committee

Jason Task Force

Final Transcript

October 8, 2014

Presentation

Operator

All lines are bridged.

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 and Health IT Standards Committee's 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? Andy Wiesenthal? Arien Malec? Deven McGraw? Gayle Harrell? Jon White?

P. Jonathan White, MD – Director, Health IT – Agency for Healthcare Research & Quality (AHRQ)

Here.

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

Hi, Jon. Josh Mandel? I believe Josh is on, unless we lost him. 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?

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

Here.

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

Hi, Larry. 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. Micky Tripathi...I'm sorry, I already asked. Nancy Orvis? Tracy Meyer? Troy Seagondollar?

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

Good morning.

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

Hi, Wes. And from ONC do we have Lee Stevens?

W

Here.

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

Debbie Bucci? And Kory Mertz?

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. Are there any other ONC staff members on the line?

M

Hello.

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

Okay, with that, I'll turn it back to you David.

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

Okay. Good morning. Micky had an unexpected conflict for the first hour of the morning and he is going to join us when he is able to, but we're going to try to get started without him, or we will get started without him. And this is our last meeting as a group before the presentation next week to the joint Standards and Policy Committees. I apologize that we didn't get the document to you until last night, both Micky and I had pretty complicated schedules between the last two meetings, so, it's a slow process just seeing our edits back and forth, but we tried to capture the important new ideas or changes introduced at the last meeting. Whether we succeeded or not, you'll have to help us tell today.

I think our plan for the morning will be to go through the two most important recommendations that have changed, because they're the ones we discussed the most on the last call. And they're the ones that I think had the most sort of policy level influence. We'll do that and see how far we get, and then if we get through the two that have changed, which are I think number 1 and number 7...number 1 and number 6, then we will focus on the executive summary and then see what remains after that.

Be thinking in the back of your minds that you might want to, if you have a chance to read through the rest of the recommendations another time and the technical appendix. If in the next day or two you want to get just lines revisions or suggested changes to Micky and I, we'll try to incorporate them over the weekend, but we wouldn't anticipate...major changes. So, can we go to the recommendations on, I don't know, let's see what page number it is, page 7 it looks like? Recommendation number 1, ONC and CMS should align...there we go. I'm going to be looking at my local copy so, a little bit easier for me to read, but we'll try to keep the screen in sync.

So, what we've captured in recommendation 1 is the point that at our last call we agreed to move up to the top, it had been sort of buried deeper underneath the description of the coordinated architecture and the data sharing network discussion and several of you, I forget who lead the discussion, but several of you said we should make this our number one point. And Micky and I both agreed so we've moved it up and kind of summarized it a little bit. So, let me just walk through it quickly, the high level points here, and then let's see what discussion we have.

So the top point is ONC and CMS should align Meaningful Use Program's focus on expanding interoperability through the use of public APIs. There is a need for transition; the current path of interoperability is based on standards that are functionally limited and unique to healthcare. The healthcare industry needs to transition to exchange based on core Internet architectural principles via development and use of a more comprehensive set of public APIs. There is currently no industry or government led plan or effort focused on ubiquitous adoption of standardized public APIs. This transition will not be easy because there are currently many demands on providers and vendors. Shifting the industry will require concentrated development work by vendors and ecosystem maturation across the industry.

Second bullet point, importance of Meaningful Use Stage 3 and associated certification; HITECH incentive and certification levers though diminishing in influence, remain the only industry-wide levers that vendors and providers cannot ignore. Thus it is very important that the public API requirements be included in HITECH Incentive requirements.

Point “C;” need to focus Meaningful Use by sharply limiting the breadth of MU requirements in return for focused requirements targeting interoperability. Recent experience with MU Stage 2 and the 2014 edition certification showed that overly broad and complex requirements can tax vendor and provider capacity. Narrowing the focus of Meaningful Use Stage 3 and associated certification will both send a strong signal to the market on the importance of interoperability and allow providers and vendors to concentrate development resources on the public API implementation.

Point “D;” we believe there are three complimentary HITECH levers that should be orchestrated. Number one, ONC should add certification of the core services of the public API to the set of standards associated with each certified EHR technology. This should be done in a manner that accommodates more rapid evolution of core data services than had been possible with previous certification approaches. Start with certification of simple services and expand certification as market experience matures.

Point two, ONC and CMS should find ways to encourage vendors to grant third-party access to public APIs based upon agreed upon fair business and legal conventions. Point three, CMS should create incentives through Meaningful Use Stage 3 levers that healthcare organizations who have implemented a public API compliant CEHRT expose third-party access to their HCO data via the public API according to agreed upon trust frameworks and data sharing contracts. So just a footnote there or a commentary point, bullet point two is addressing the vendor side and bullet point three the providers who deploy the systems.

And then finally, point “E;” timing is critical. JASON recommended that ONC develop a plan for an API based architecture within 12 months; however, the MU Stage 3 timeline is shorter than that. ONC should immediately leverage the FACAs to solicit and provide feedback from the market and other government agencies to validate and further flesh out these recommendations. ONC should immediately contract with an SDO or other recognized, operationally active industry consortium to accelerate focused development of the initial public API, core data services and profile specifications for inclusion in MU Stage 3 and associated certification. And finally, leveraging the MU3 lever will require acceleration of standards definition and technical development on the private side and adjustment of the MU Stage 3 rulemaking process on the public side.

I apologize for reading that whole thing, but I think you have to kind of see it all together to make a reaction to it. So let me stop and see what people say, do we capture our group’s sense? Have we gone too far? Is it not far enough?

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

So this is Josh, I’m sorry; I got disconnected just before the roll call. But this is much stronger than the version we reviewed last week and I’m very happy with the direction that its gone in. I would make only a couple of small comments, and they are both to do with timing, section “C.”

Those two comments are, number one, the 12 months that the JASON group recommended, just to fairly capture what they recommended, was 12 months from November of 2013, when they published their report. So we've already used up 11 of those months, just to give those guys fair credit, in terms of their timing with respect to Meaningful Use. And in "C-4," when we say that we'll require acceleration and adjustment, I just want to be clear, when we say adjustment, do we mean delay, and if so, we should say that.

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

Which one was that last comment with respect to, Josh? I've lost track, which...

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

Sorry, the very last bullet point in this section, leveraging the MU3 will require acceleration and adjustment.

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

Ah, "E-4," okay, I thought you said "C-4," that's what I was thrown off by.

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

Oh, I did say "C-4," my eyesight is still a little blurry at this hour.

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

Yeah, I appreciate you're being up and at 'em so early on West Coast time. Well, I...yeah, so I think it's a vague statement because obviously we are not in a position to tell CMS and ONC how to do this, but it's just sort of a notion that it would require adjustment, whatever that means operationally. I mean, I realize...I believe here that we're making a strong statement; whether it can be acted on under the current processes, I don't know. But I think our process...our job is to recommend what we think should happen and let ONC/CMS figure out how to get there, if there is a way. But your suggestion on 4 would be to say slow it? What would you...how would you suggest changing it?

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

I would say this could even imply a delay in the process to accommodate these changes or something, just to make it clear that we understand that the timing for this may be different from the timing that's currently anticipated for MU3.

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

Yeah.

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

Again, like you said, I think our job is to suggest what should happen, not to make too many assumptions about what the process or the timeline looks like.

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

Wait a second; this is the other Larry Garber. I actually think we should explicitly say that ONC and CMS should explore delaying MU3, what their options are. I mean, because the reality is, I mean we're all looking at this; we all know that this is going to be insanely tight and probably impossible without a delay. So, I think we should at least put it right out there, they should investigate whether that's an option.

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

Okay. That's two strong statements, I will third the notion, and I think that's a reasonable thing to call for. It's a hidden call now, but we can make it explicit.

Wes Rishel – Independent Consultant

This is Wes.

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

Yeah.

Wes Rishel – Independent Consultant

I would sort of consider the possibility of adding delay or stagger the requirements for Stage...Meaningful Use Stage 3 in the sense that it may be that they have some options for rulemaking that allow them to meet any legislative deadlines while still giving the standards time to cook. Have we, in the findings, have we made the case that...of what the recommended public API is and what status it's in now or is that going to come further in the recommendations or both?

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

Um, so in the recommendations section, there's a high level definition of the...what we're calling the public API.

Wes Rishel – Independent Consultant

Yeah.

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

And then in the technical appendix, it gets a little bit more precise...

Wes Rishel – Independent Consultant

Right.

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

...but we also, I think, fully expect that this process gets handed off to the FACAs for actual refinement into something very concrete.

Wes Rishel – Independent Consultant

Yeah, okay.

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

And that's what's called here for in "E-2," immediately leverage the FACAs to solicit and provide feedback from the market development...

Wes Rishel – Independent Consultant

So we're not...yeah, so I think that somehow one of the issues that was inherent in the JASON Report was the timing required to develop a public API and what our recommendation 1 here says is that it takes some time and that there are candidates in the industry that are part way along. There is experience with private APIs, but the process contemplated by the JASON Report needs this extra time and specific focus in order to have a public API. Now, it may be too late to introduce something that broad into the statement, but I'm finding that as I read recommendation 1, and try to put myself in the shoes of someone who's not a standards geek, I find that it just sounds like delay, it doesn't...the need, the urgent need for the delay isn't well motivated.

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

Okay, so you're saying you agree with the notion of adding in explicit mention of delay, but make sure it's tagged to the work necessary to mature the public API.

Wes Rishel – Independent Consultant

Make the requirements already have been present in the document by the time we get to that recommendation, right. Make at least a statement of the breadth of the requirements or the work that's necessary.

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

Okay. So, some of this may be covered later when we get to bullet point 6 or made the recommendation 6, I don't honestly remember in my head, so Wes, keep that thought in mind.

Wes Rishel – Independent Consultant

Well if nothing else, then at least a phrase in the recommendations that helps justify this cause for delay.

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

Yeah.

Wes Rishel – Independent Consultant

Okay, thanks.

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

Good comment.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Hi, it's Larry, yeah, the other Larry.

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

Which Larry is the other Larry; I can't tell your voices apart.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sorry, this is Larry Wolf.

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

Okay, Larry W got it.

Wes Rishel – Independent Consultant

It's the other brother Larry.

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

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And so I like that we're being really clear and we're pushing the envelope here in many ways, but I kind of feel like we need to address somewhere in here, acknowledgment that there are other things already in place and under way that people are looking to build on and roll out. And that maybe we need a roadmap here. I sort of feel like I'm in a city that made a commitment to heavy commuter rail and has got the first line running out to the suburbs and then someone said that's not fast enough, so we put in a lot of bus service and now we're building light rail.

And I know we're trying to get to critical mass and we're trying to move things forward but I sort of feel like I need an overall roadmap to make sanity out of the existing document query stuff that there is a lot of activity on, even though everyone says it's not as good as we'd like it to be. The fact that Direct is...was supposed to be really simple and turned out to be not so simple in its implementation and is the primary reason people are saying that they're late on their MU2 these days, after initial delays getting stuff from vendors. And now we're saying we want to accelerate development for APIs. So I feel a little bit shell shocked.

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

Yeah, so the call for changing the requirements of Stage 3 was our sort of give for the...or our get for the give of, let me try to say it from who's perspective, let me just say it straight up. In exchange for increasing the effort on interoperability by implementing the public API, we are calling for them to delay and/or reduce the complexity of Stage 3. So from a go forward point of view, that's the tradeoff we're calling for. Later in these recommendations we make it clear that existing networks, data sharing networks, which would be the Direct and the query networks that are emerging, would continue and that they would then adopt the public API when it's available and when it helps them with their services.

In other words, they presumably would find it useful to expand and increase the power of their networks with the public API. So we're certainly not calling for them to stop, this is targeting what gets done next, when the next RFP...not RFP, the final rule drops or preliminary rule and final rule, what does it ask us to go do. We're going to...we're saying simplify it, focus more on interoperability, consider delays or staggering, as Wes suggested, but it's not...

Larry Wolf – Health IT Strategist – Kindred Healthcare

I like a lot the notion of staggering...

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

Um hmm.

Larry Wolf – Health IT Strategist – Kindred Healthcare

...because I sort of feel like we're still in an experiment with FHIR, assuming that's our best candidate and it would be great to get a lot of experience, and in some ways let the market lead the regs by people building on early prototypes, early vendor availability. And starting to create some infrastructure and clear direction from ONC that this is where they think things are going so people don't feel like they're frozen in place and are going to wait for the shoe to drop. But I think some notion of really staggering a roll out, so that there is time to shake out issues and preliminary implementations, if you will and still have something that's in the marketplace that can be built on.

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

Yeah, we do clarify that a little bit later on. The point in this summary bullet, which may well be the only thing anybody reads, which is why we spend a lot of time on it, is it's not terribly clear, perhaps, but the certification process, I said that line in there, start simple and iterate as, yeah, iterate as market experience matures. So yeah, "D-i" start with certification of simple services and expand certification as market experience matures. That was intended to capture the thought that this will not be a one and done...one standard...once specified for certification you're done, this will be something that iterates perhaps as frequently as yearly. And we were following on Steve Posnack's suggestion that the new approach to certification could accommodate a more rapid iteration and versioning, if you would, of the certifications. So maybe the connecting of the dots isn't clear, but we're counting on that that wor...that the new approach works better.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, I'm wondering if "A," need for transition might address some of that that you just described.

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

Adding a bullet up there?

Larry Wolf – Health IT Strategist – Kindred Healthcare

That some of this transition also has to show up in the certification process.

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

Oh, I see what you're saying.

Larry Wolf – Health IT Strategist – Kindred Healthcare

My concern is we're going to get in the problem we had with the quality measures, vendors weren't certifying products because the quality measures weren't finalized and so nothing was being released until very late. And I'd hate to see that happen again around APIs this time.

Wes Rishel – Independent Consultant

This is Wes piling on again. We know, I mean, the statements from HL7 are that they're under DSTU with FHIR, that they're committed to making non-compatible changes in the specification as a result of what they learned through using the DSTU and then they're committed to stabilizing the specifications on the first...release of the standard. Are we...what are we calling for here in terms of activity, HL7 completing release 1 of FHIR in time for vendors to build to it for certification under Meaningful Use Stage 3?

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

So this is Josh, I don't think we can be calling for that because HL7...if the FHIR group's timeline is years between now and the normative edition, there will be a second draft standard in between.

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

Well this is a dilemma that we faced from the beginning, if we want to do this as part of getting vendors to actually do it because it matters, leveraging the pressure that certification and the incentive programs can bring, we have to do it soon, and that is faster than the HL7 current timeline. So the place where we, you know, in this particular recommendation where we touch on that is the timing is critical, section “E,” bullet 3, ONC should immediately contract with an SDO or other recognized active industry consortium to accelerate focused development of initial public API and core data service profile specifications. Then, okay, there is some hand-waving there, but it says, if we want to do this there has to be a specification.

Wes Rishel – Independent Consultant

I think there’s a lot of hand waving. I think that in a private email, Arien had a quote a few days ago about how this process has gone astray by attempting to prematurely formalize and demand full nationwide implementation of standards that aren’t cooked yet. I think with FHIR we have the first time I’ve ever seen an SDO go through this process of not publishing a standard and expecting adoption but really making use of the DSTU process the way it was intended. For us to come back and recommend, oh don’t do that I think is possibility meeting the definition of lunacy of doing the same thing over and over again and expecting different results.

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

So I’m not sure, Wes, I don’t think anybody’s calling to stop the DSTU; you’re saying the lunacy would be to speed it up...

Wes Rishel – Independent Consultant

Yeah.

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

...for a core subset? You don’t think you could carve out a core subset and...or the kinds of core data fields that we share...

Wes Rishel – Independent Consultant

I don’t know that’s a good point and a point I wasn’t fully taking into account. And I don’t know the answer to that question. I do know that we are aware of no other alternative, at this point, that comes close to matching the vision of the JASON Report and we are not...we don’t believe that any...the process to develop any radically different alternative and move it out to a national implementation could happen any faster. So, I guess you...I mean...what’s his name here, Josh, Josh is closer to the project and better able to comment on whether the possibility of some really core API could be accelerated and brought to a normative edition faster than the current process, which is a fairly...which is apparently broader than that. So, why don’t I shut up?

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

So I’ll just say really briefly, Wes has captured it correctly that there will be breaking changes in the FHIR specifications from the first to second draft standard and presumably from the second draft standard to the normative edition. That’s all in the future. What I would say is, what’s out there today, right now in the first draft or early next spring in the second draft is already more...it’s already very useful in its own right. What I would like to be able to do is capture the notion of using what’s out there and already useful, but not limiting ourse...not locking ourselves in to the incomplete state of specification from 2014 or 2015, having a way for the community to upgrade, even if that’s across breaking API changes, to upgrade to keep up with those changes as we go forward.

Wes Rishel – Independent Consultant

Yeah and in Josh’s saying that, I think I’m finally tumbling to where you guys have probably been for some time, that with some thought to that, pardon the expression, asynchronous upgrade that it would be possible to specify some very subset as a provisional or just use the DSTU, for that matter. But the requirements on the certification side would have to be a lot stronger than any requirements for use of that on the Meaningful Use side. In other words, generally I feel that requiring certification doesn’t matter much unless there’s a Meaningful Use requirement to use what got certified. Here I think we think that the basic capability is so general that if people are certified for it, they will find uses for it bilaterally or and so forth, or even between an EHR in a healthcare delivery organization and other programs in the HDO, that make it worthwhile.

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

Yeah, I think just Wes, to respond to that, I think that was the...Steve Posnack clarified for us that the certifications are all neutral, they are just certifications. They have to be tied to a particular incentive program to become required or not required, so certification in and of itself is just a certification. So I think one of the thoughts here that we discussed in our earlier calls was, a certification focused around a core subset rapidly developed by whatever process we can muster, even if not attached to any incentive program gives everybody a target to start working on. It’s a statement of where we’re headed.

Wes Rishel – Independent Consultant

Well, it’s attached to the incentive program just by being a certification. I mean...

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

Yeah, yeah, although nobody would be required to test to it unless they want to...

Wes Rishel – Independent Consultant

Nobody would...well then, okay, now I’m off again.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Certification is modular.

Wes Rishel – Independent Consultant

Voluntary certification of a feature that your customers are not going to be required to implement and you’re not even required to be certified by it, that’s what we’re talking about?

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

Well, it's a...it would be...essentially all certifications are voluntary in the sense that you choose to do them if it matters to the incentives that you're interested in achieving. So, it's as somebody chimed in there, it's modular. So a particular incentive will say, this set of modular certifications is required, this is how I understood it and, you know, this is not my strength.

Wes Rishel – Independent Consultant

Um hmm.

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

So a particular set of certifications could be required...so we could go into this modified Stage 3 with a new certification for a simple subset of the public API, but no particular incentive that requires it. So what the vendors would know is that eventually this was going to matter, so get working on it and in fact, you may discover uses for it right away that help you in your market, even though it's not tied to...

Wes Rishel – Independent Consultant

So, this is...what I'm missing, I'm sure this was discussed while I was out after surgery but, what I'm missing is that there...the general notion in the incentives that you have to have certified EHRT has been modified so that you don't have to have all certifications in the certification program, you only have to have the ones you need in order to do the Meaningful Use things, right?

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

That's right. There's no such thing as a complete EHR any more in the new way that ONC has structured it.

Wes Rishel – Independent Consultant

Right. Yeah, okay, so the certification we're requiring is not required, it's voluntary. All right, okay, I...sorry I've been listening to these calls for a while not realizing that I had overlooked the stuff that happened while I was out, so, apologize for that.

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

No, Wes, your questions are absolutely on target and are helpful in clarifying. I think this is very confusing. We had an email thread with Steve Posnack that was...it accidentally didn't go to everybody and we never really had a chance to get Steve on one of our calls to go deeper on this, so some of this is based on what we interpreted the final rule to mean and what Steve...how Steve is trying to clarify it.

Wes Rishel – Independent Consultant

Okay. So fundamentally what we're saying is for Stage 3 certification, we ought to get something in there that nobody has to do.

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

And Wes, "D-3" says that CMS should create incentives through MU3, so that's where there the...

Wes Rishel – Independent Consultant

Oh, okay.

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

...that's where we can come full circle and close the loop.

Wes Rishel – Independent Consultant

All right.

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

Well and it's contingent on giving up something that we would hope would be less important that achieving interoperability.

Wes Rishel – Independent Consultant

Right.

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

In other words, if there are six capabilities, six capacities in the system and we want to add this new important focus on interoperability, you've got to give up something or delay substantially. And if CMS says we can't, then I think the whole thing unravels and we say, well you shouldn't put this into any kind of an incentive program for Stage 3.

Wes Rishel – Independent Consultant

Yeah, okay.

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

So it's kind of a package deal and maybe that's not captured here, but that's what we're trying to get at with this complex point number 1.

Wes Rishel – Independent Consultant

Well let's go...I mean, in theory...according to the agenda, if we have time we'll look at the executive summary. Let's see how the executive summary and to be honest, I haven't read it yet, but let's see how that does in terms of taking the concepts out of the words and extracting the important concepts and bringing them up front.

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

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, this is Larry Wolf, let me jump in with a reflection back on MU Stage 1 and one of my frustrations then and I think we're trying to address that here, but I want to make it explicit. So in Stage 1, certification said, we need to support both CDR and CCD and we needed to support problem lists that were ICD-9 as well as SNOMED codes. And there were a lot of places where things were "A" or "B" were both acceptable. And I always felt that it would have been much more helpful to have said, we've chosen one and this is the one that is our roadmap, but for this first stage or this next stage, we're not going to penalize you if you're using the other one but you're not going to be able to do certain things because it's going to be the wrong standard. But we're not going to endorse the wrong standard, because we want to be clear that we want to set a direction.

And I sort of feel like that's what we want to do here, we want to give a very strong signal that we believe FHIR is the right API, that we want to see it get in use, we want to see it tested in real environments and not just in sandboxes. We want to sort out the operational issues of how do providers actually make access possible using these APIs that have all of the kind of governance and framework that's spun up around Direct to make it work needs to spin up around the APIs to make them work. And so I feel like part of our job is to be very clear about direction and to be clear about roadmaps so people know where we're going and what they need to do to get there.

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

David here, that's very well said and I think that's what we're trying to say here.

Wes Rishel – Independent Consultant

This is Wes; I think we're trying to fall just short of naming Direct, right?

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

Well we're not...yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

...naming FHIR?

Wes Rishel – Independent Consultant

Yeah.

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

Naming FHIR, is that what you meant?

Wes Rishel – Independent Consultant

Naming FHIR, that's what I meant, yeah. Right.

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

Yeah, we make a strong statement of recommendation for FHIR and we could go ahead and recommend it, I don't know that there's any reason why we have to be slightly indirect. The thought is that we're handing this off to another workgroup, the API and Architecture Workgroup that will pick this up and run with it, so I think the thought was just to give them a handoff that had a tiny bit of flexibility. But as somebody said earlier, I think it was you Wes, there is no other choice. I mean, there is no other standard that is anywhere close to doing what we're talking about here, other than FHIR. It's a no brainer, so unless there's some magic that I haven't heard about...hasn't been brought up...

Wes Rishel – Independent Consultant

No, but I think we need to...that sort of assumption coming out of the Task Force begs for revalidation through the process you're describing, I mean...

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

Yeah and so the Task Force, the API and Architecture Workgroup, which overlaps with this Task Force considerably, on purpose, will turn that into something much more concrete. But so Larry, back to your point, do you feel that we...you bring up the word roadmap again, are you thinking by roadmap we need a specific sort of bulleted statement of what the roadmap looks like timing wise or what would you like in the roadmap?

Larry Wolf – Health IT Strategist – Kindred Healthcare

I feel like we need to acknowledge...so, this is in some ways trying to dance around regulations that inadvertently become ceilings rather than floors that enable things and so some of my thoughts, and I don't know that they're really all that focused as conclusions yet, are that we've got to be really clear where we want to go and that we know that we want real use of things and knowing that they're going to be preliminary, knowing they're going to change, I think about the various USB cords I've had in my life, you know, with mini and micro and 1's and 2's and all that stuff. And I've sort of dealt with the relatively minor glitches and having to toss out a cord when I no longer have the device it worked with.

And so some of that rejiggering is going to have to happen here and so we shouldn't pretend that that's not...that there aren't going to be minor bumps in the road as this moves forward. And that's why I think all of this trial use stuff is really important, just to get things out there with people knowing this is to really shake out some new things. And that it, in some ways we don't want it to exclude the natural next steps of all the things that are in place, because they're going to be essential learning tools as well. We're going to need to actually get a high volume of CDA documents to start to shake out issues around code sets, to shake out issues around how do you do good reconciliation when you get a document in and you want to import the content, but it needs a process to review the information and integrate it into the patient's plan.

I'd hate to see that work stop because people said, oh well, there's a new standard coming and so it's going to be API based and it's going to be a whole new world and we shouldn't worry about these existing things. So, I'm just really...I'm stuck in that...

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

This is David again. I mean, the tension is if at some point we have to transition to the more powerful APIs, that the JASONS were right and the current approach is limited, documents get us value, but not as much value as is possible, so we have to make that transition somehow. The question is, how can we do it in a flexible way and what we're trying to capture here is the tightrope walk a little bit...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

...by saying, let's start with a simple core set of services that address sort of universal needs, put it into a certification that may not actually be bound to any particular incentive. But which will focus the vendor community and the network developing community, the CommonWells and e-Health exchanges of the world on the future, so that they can begin to build that into their roadmap, start developing services around that simple API and at some point it will converge to new capabilities that match a certification point...I mean, an incentive point in the future, which probably won't be Meaningful Use, frankly, because it runs out of gas after this one.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. Well actually, so you're compelling me to clarify something that we've been saying that I don't believe is true. The stages are a construct that was created early in the MU Program, but are not specifically in the legislation. So there's nothing sacred about MU3 as the end point, this was arbitrary, we can see as far ahead as three stages. The other piece is that the incentives are essentially over and are about to turn into penalties, and those continue forever. So the MU Program doesn't end in a year so I think this notion of this is our last chance may, in fact, be true but not because of what's in the law, it's more about attitude and intention.

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

This is Arien. So first of all, joining late, thanks for starting it at 6 a.m., but there is an important...

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

Hey, Arien, your West Coast colleagues managed to make it early...

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

I'm sure they did, thank you to them. There is an important point though which is that in a program where you're putting significant investment dollars on the table, you also have an ability to change practice, to change technology in order to get access to those dollars and an ability...in a world where you're effectively saying that using a...meaningfully using an electronic health record is a prerequisite to reimbursement at par. You explicitly are at a floor and it's not clear to me, and there's a whole policy issue here that I don't think anybody has ever adjudicated, but it's not clear to me that you get to push as hard in a world where you don't have...in a world where you're effectively saying this is the floor for getting reimbursement. So I do think there's a policy assumption here that we need to be looking at Meaningful Use and other levers as focus areas for driving this new world. That doesn't take away any of your other points, I just wanted to throw that in there.

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

Yeah and...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah...actually the incentive flow, this is the last year.

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

Right, that's right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

It's going to turn off before MU3 because of the delays.

Wes Rishel – Independent Consultant

You know, I think it's important for us to recognize that on the one hand, penalties are incentives, on the other hand, the political calculus involved in creating regulations is...may be found to be less supportive of aggressive reinvestment in this thing. And it's important for us to understand that and then not bring it up in the report in the sense that that's sort of...the scope of this report is hey, this is a great idea, hey, it's going to take a lot longer. Hey, here's what we've learned with other efforts that is positive in terms of laying out the roadmap for creating a public AP...an operational, nationwide use of a public API. Hey, there's localized use of a public API such as use within an HDO that is also a benefit and can provide an interim path and let's get busy. I mean, that's really what we want to say, right?

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

Yes, it's David; I think that's the balance beam that we're trying to walk. Clearly ONC has said to us in the last number of Standards Committee meetings and I think in the policy meeting that I sat through; there will be other levers in other incentive programs beyond Meaningful Use. They don't all come under HITECH, but they can and will reference certification. So, we don't know exactly what those programs are, but they're telegraphing that there will be more of them. So the certification part is valid as a signal for all sorts of future possibilities beyond and independent of the current Meaningful Use; however, Meaningful Use is what we're all living with right now so the degree that we can leverage that by freeing up some energy from unnecessary requirements and shifting to these APIs, we think that's a good idea, if you can pull it off, CMS. And maybe they can't, but we can recommend or at least that's how I'm thinking about it.

Wes Rishel – Independent Consultant

Okay, but I think what we're hung up on is the conflict of Meaningful Use Stage 3 deadlines versus the timing to get something meaningful and reasonably stable out of the door, so...

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

In terms of FHIR, you mean...

Wes Rishel – Independent Consultant

Yeah, yeah. I mean, because that's the only prospect we see right now.

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

Yeah, yeah, no, I just wanted to make sure that's what you were talking about.

Wes Rishel – Independent Consultant

Right, yeah. And being able to point out that...or at least request that there be other incentives other than requirements for conformance to Meaningful Use Stage 3 in the future leaves us with a simpler path towards this sort of, if you will, I don't want to say nominal but definitely minimal functional requirement for voluntary certification under Stage 3 without necessarily having a functional requirement as part of Meaningful Use Stage 3, which is where I think on the one hand, these 5% and 10% functional requirements are the only thing that really gets stuff implemented nationwide. But on the other hand, we've seen...we're trying to avoid cooking our frozen meal with a nuclear bomb here and this is the path we've found through the middle. So, I think I'm more comfortable with the language that we have, providing that there's somewhere that it sort of calls out a little more cleanly what we're talking about, perhaps in the executive summary.

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

Okay. Any other comments? Maybe we should go and review point six, because it's kind of...

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

Actually before you jump to that, this is the other Larry Garber. I think the one thing that I felt was missing from this section 1, and it probably would be bullet "D," it would be the new bullet "D," in other words, inserted between "C" and the current "D" is that one of the key problems that I've seen with Meaningful Use Stage 2 is that there were incentives to send information, but there were no incentives to receive information. And as a result, we have lots of people who configured the ability to send and found that they had no one they could send to and I wonder if we ought to specifically call out the need to have MU Stage 3 incentivize both sending and receiving of information with these APIs.

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

Interesting question, an API...the APIs under discussion at least, the FHIR APIs kind of imply a roundtrip, I mean there's a connection between sender and receiver that has to exist.

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

Well in other words, you could be setting this up...if we're incentivizing to turn on the API to be able to send information responding to a query but don't incentivize the queries of that information, or vice versa, we're going to fall short. I mean, they are different commands, whether it's a get or a send or whatever, you know, they're different commands and I think we need to make sure that we incentivize the whole package of both sending and receiving and not just a piece of it.

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

Yeah, this is Arien. I do think though that to some extent you open APIs into your EHR and they're not useful, that is, there's no useful service that you can use or purchase or add on that is...that takes use of that data. It's not clear to me what incenting the other side of that transaction is going to do for you.

Wes Rishel – Independent Consultant

Umm, this is Wes. I...first of all, I wondered if Larry, other other Larry, would accept a friendly amendment that didn't just focus it on Meaningful Use Stage 3 since there are other incentive programs. I'm concerned that by creating a 5% incentive for some kind of interoperability based on a public API in the timeframe of Stage 3 we are going to be repeating that which has happened before and expecting a different outcome. So putting...the principle that Larry calls out that unbalanced incentives makes it extremely difficult to achieve inter-organizational interoperability is a very important principle that goes in here somewhere, I just don't want us to focus too much on Meaningful Use Stage 3 incentive qualification as opposed to Meaningful Use Stage 3 certification.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, this is Larry Wolf, if you were talking about this Larry...

Wes Rishel – Independent Consultant

No, I was talking to Larry Garber, I'm sorry. Go ahead, Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay, the other Larry will have to respond then, I've got some comments as well, but go ahead Larry Garber.

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

Wes, I always accept your friendly amendments, so of course.

Wes Rishel – Independent Consultant

Friendly amendment to triple my salary on the Standards Committee.

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

Done.

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

Yeah. So just one comment on the Wes-Larry discussion, I think that one of the higher level principles, not necessarily part of this report at all is that the incentives ought to be around desired outcomes and the certification around the APIs is done in the belief that the APIs will be useful towards those outcomes. But anything too granular about trying to create an incentive around how to use a particular piece of technology is where I think we get into trouble. I mean, we have every reason to believe, based on our considered judgment that the exposure of these APIs will, in fact, facilitate achievement of many desirable healthcare outcomes and I'm not sure we want to create incentives on exactly how you're supposed to use the API.

I mean, it's not our call to tell what these incentives are, we're not a FACA of CMS, but, is that...I mean, telling people they have to use Direct to do a transition of care is a mistake, you know, creating Direct and saying it needs to be there and that people need to be able to use it and then saying you've got to do a transition of care and people naturally discovering that Direct is a way to do the transition of care for some people is a much better approach, I think. Does that make sense or am I...

Wes Rishel – Independent Consultant

Oh, I honestly think that my experience with interoperability is that there are humps you have to get over before a given technology becomes the easier choice, and a lot of those humps are not technological; they are governance and often cultural acceptance of the underlying functionality. And that failure...if, in fact, it's in the interest of the nation to deploy a new set of standards but not in the short term interest of any one organization, then it can be very helpful to have an operational requirement to use a standard.

Having said that, in general I don't think that we have an option, you know, FHIR and whatever else anybody might propose, I don't think we have an option to make that level of requirement at this time. I feel particularly good about the possibility that non-int...intra-organizational use of these public APIs will allow it to develop using the natural incentives of business, hey, we can do something better, we can make a better bed board for nephrology, we can create...we can do the kind of stuff that SMART does now and without necessarily having to get over the interoperability hump. Building that in the infrastructure then makes it easier to make the move later on towards some required inter-organizational interoperability.

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

Yeah, this is Arien. There is a point that, and I now forget which Larry, but some Larry made and it's...all points the Larry's make are good, that is really important which is that usability makes interoperability.

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

Say that again, Arien, you got garbled.

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

Usability makes interoperability and so I've been thinking about the experience with Direct. I actually believe...I'm not exactly sure how you work around this problem, but I actually believe that if Direct had just been an option, EHR vendors would have done the minimum necessary, plugged it in and we would have had an even worse ecosystem problem. I'm not exactly sure how to make...how to use incentives to make Direct useful, but at the very least requiring them to be used at least created a somewhat painful approach.

FHIR, to be useful in a pure disconnected, standalone world will be useful for some things, applications that can run headless. If you don't have some kind of context management, something like what SMART does, there are going to be a whole set of uses that will be horrendous from a user experience perspective and no incentive to build in and standardize those hooks for context sharing and other kinds of hooks that make the experience of launching a FHIR App usable in workflow. I'm not exactly sure how you work around that or how you build that into the language we're talking about, but there is an important point there.

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

Well, I...this is David, I sort of disagree. I mean, I think that it's a bad example to go to the Internet...it's not always a good example to go to the Internet but, we didn't have to tell people how to use browsers and web servers to achieve useful outcomes. They had a simple tool and it exploded because there were so many useful things you could do with it, nobody was pushed to do that.

I think exposing these APIs creates opportunities for people to do things better than we can do today with the current technologies and vendors will have incentives to go figure that out. Networks will have incentives to figure that out, the networks that do the API level integration will be better than networks that only do document level integration. And the market will figure that out, we just have to get everybody on the same page with what the core minimum services are...

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

Yeah, I think that's the key thing...

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

(Indiscernible)

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

...and I'm not sure that they're just data...they're just core data services, there may be some context sharing services...

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

We ac...good point and we call that out. I did add that to our technical detail...

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

Okay. Okay. That's fine.

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

...that not all services...the public API may include additional services beyond data access services at sort of minimum necessary for things like security. And then we're handing this off to your group, Arien, so you can flesh that out...

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

Woo hoo.

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

...in the next months.

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

...catch.

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

We can pick it up. Let me suggest that we shift to, because we used up half our time, I want to shift to point number 6, which is equally on the policy and regulatory side of things. I had hoped that Micky would have joined us by now, he said he would be here at the hour. So, I've been kind of delaying, because Micky wrote all of number 6 and it makes me...I'd rather have him walk us through it than me. But let me get it started under the assumption that he'll join in in a few minutes. Is everybody okay if we shift to 6, because I think it overlaps with some of these discussions and it does need some talk.

So, are we showing that on the screen...yeah, okay, so good. All right, I'm going to buzz through it here just so we all hear the words. ONC should assertively monitor the progress of exchange across data sharing networks and implement carefully crafted, non-regulatory steps to catalyze the development of data sharing networks and the coordinated architecture. So we're going to be talking here about some ways to push this forward.

Point "A," need for market ecosystem to support the public APIs. Recent market experience with Direct makes clear that implementing a technical standard is not enough. Technical standards must be embedded in a market ecosystem of reasonable or customary practices in order to work seamlessly across all settings. Regulatory solutions are unlikely to be effective. ONC and CMS do not at present have clear regulatory authority over the activities of these data sharing networks. Developing and imposing strong regulatory authority would be complex and difficult to calibrate, given the large number of disparate, heterogeneous, emerging networks and the various different use cases of those networks...

Number 3, leveraging local governance; data sharing networks will already have governance in place for their own network activities. Alignment of these governance mechanisms to support loose coupling is a much higher leverage and feasible approach than a top-down regulatory directive. Attempts to supersede or displace existing data sharing network governance models would negatively disrupt the current rapid growth in these local, regional and national exchange networks.

And then "D," coordination by a critical mass of exchange networks may soon be achievable. Market conditions have historically been difficult in healthcare due to high fragmentation. However, current market trends point to the possible emergence of a critical mass of operational health exchange networks with growing national market presence, which could make market-based coordination more feasible than it has been in the past. Such market-based coordination has developed in many other industries where a critical mass of organizations form a collaborative governance and operating principles.

Point "E," federal government can take several key steps to help industry overcome competitive and coordination barriers, and here's a list of some. It's a long list, I'll...through them quickly, first, transparency; aggressive and ongoing public monitoring of the pace of development and the use of network mechanisms; number 2, guidance; issuing authoritative ongoing guidance to provide industry wide direction and benchmarks and to encourage specific actions for the development of data sharing networks and coordinated architecture.

Number 3, organization; convening existing exchange networks, i.e. prospective DSNs, to catalyze adoption of the public API and development of the industry-based governance mechanisms. Four, DSN bridging standards; developing standards for vendor-neutral cross-DSN bridging to fully enable the narrow set of robust transactions required for the loosely coupled architecture including possibly patient identity reconciliation, authorization and authentication strategy key management, etcetera.

Five, nationwide shared services; developing standards for and ensuring development of universally necessary shared services that are highly sought after and thus would facilitate DSN alignment such as public use licensed vocabularies and perhaps nationwide provider and entity directories, etcetera. Number 6, incentive alignment; aligning incentive programs and existing regulatory processes to incentivize use of the public APIs such as ACO contracts, LTPAC regulations, lab regulations, etcetera. Those are some of the other levers that we mentioned earlier.

Seven, federal operational alignment; requiring federal healthcare entities to adopt the public API in their technology procurement activities and day-to-day market interactions such as Medicare/Medicaid, the DoD DHMSM, the VA, Indian Health Services, NASA, etcetera. Number 8, regulation as a backstop...a space missing there; the government should consider direct regulation of data sharing networks in the event that the market does not develop effective coordination mechanisms as measured by reasonable, but meaningful benchmarks.

As noted earlier, such actions would involve significant increase in the government's regulatory authority over health information exchange, which would have the risk of unintended consequences that could slow market progress. Any such increase in regulatory authority should be carefully considered and specifically calibrated to address any remaining barriers that the market has failed to overcome. So, a lot of words.

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

That's a mouthful.

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

David, this is Micky, I'm on.

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

Oh good Micky, it's yours. We're doing number 6.

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

My timing is perfect, you just got through the long list, excellent.

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

That's right, so Micky and David, do...before I try to wade through comment here, do 6 and 7 belong in this section? Or I guess I would say, it doesn't seem to me that 6 and 7 belong in this section. They don't address oversight or promulgation of or etcetera for data sharing networks. They seem to be trying to find other non-Meaningful Use incentives for use of public APIs.

Wes Rishel – Independent Consultant

They seem to be catalyzing, which is in 6.

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

Yeah, but they're catalyzing use of public APIs, not catalyzing use of data sharing networks.

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

Right. I mean, I guess the idea here is this is a spectrum of actions that the govern...of non-regulatory actions that the government could take to push any part of sort of the public API, DSN, CA construct that we think would be directionally right and effective. None of them on their own, but perhaps all of them sort of...could do that.

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

Yeah, and I'll keep pushing on this one, but it does seem to me that these two could be pulled out as non-Meaningful Use incentives for use of public APIs that would be independent of data sharing networks.

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

I see, so you see all the other ones as being sort of the Meaningful Use...the authority would come from Meaningful Use.

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

No, I see the other ones as being specific to the notion of use of data sharing networks.

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

I see. Okay.

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

Versus other uses of the APIs, is that what you're saying?

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

Versus other, so for example here we're pointing out in 6 we're pointing at use of ACO contracts, LTPAC regulation, CLIA, etcetera to create additional incentives for use of public APIs. That seems to stand alone as a policy recommendation, independent of whether those APIs are managed, endorsed otherwise through data sharing networks. Federal operational alignment, same thing, we're recommending the VA, DoD, etcetera use, adopt, deploy public APIs independent of whether they do so through a data sharing network or on their own.

Wes Rishel – Independent Consultant

So broadly speaking, this is Wes. The concept here is that bilateral exchanges could happen inter-organizationally by doing all of the governance at hand that would otherwise be included in a data sharing network, is that what you meant by...

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

That's right. So DoD probably will create its own and VA may go through e-Health exchange, may build these APIs into VistA or into DoD's newly procured EHR and that may well be completely independent of participation...decision to participate in e-Health Exchange, CommonWell, Care Equality, FU...you know, network.

Wes Rishel – Independent Consultant

Yeah, okay.

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

Yeah. So Larry and Arien, let me clarify then because I see what your point is and it's a good issue. I used the term data sharing network to be very much broader than just the kinds of networks that we have today, those that you listed. So essentially, any use of the public API to move data around, coordinated in such a fashion that you deal with the issues of contracts and authentication and all the requirements for moving sensitive healthcare data, that's the data sharing network. So, I would consider, for example, Smart Apps that plug into the EHR using the API, that's a data sharing network.

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

Umm.

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

So perhaps the word network is wrong, it has too many connotations, but just so you understand where we were coming from, network is a broader notion than just the things that we do today that we call networks.

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

Hey David, it's Keith. One...just, I think to that I just want to add on that point. What doesn't look like it's in the document, that you may want to put either in the technical appendix or you may want to build it out further in recommendation 2 is the point that you just made, which is a more clear definition of DSN.

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

Yeah.

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

Because I kept getting tripped up in reading through this on exactly what you meant by DSN, because I think everybody has got a different impression of what that is and then your point just clarified that to me, which I think we need an additive point to this document that really clearly says what that is.

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

Yeah, so, that's good feedback and I worried about that that what we were trying to account for there was the kinds of things that didn't get accounted for with Direct. So you put out a standard and you tell everybody they have got to implement it and then they discover they can't use it because the missing glue, trust frameworks, directory services, etcetera, aren't there. So the data sharing network notion was designed to capture the fact that in order to use these APIs in the real world, you're going to have to have these agreements in place, and we think there are so many different use cases that you can't do it with a single federal, top-down mandate on how to do it. There won't be just one trust framework, there won't be just one authentication process. So that's where these data sharing...maybe it should be data sharing agreements, maybe that's a better word, I wonder. Micky, does that make better...

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

I was wondering, was that Keith who had that comment?

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

Yes it was.

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

Yeah, hi Keith, it's Micky. So I'm just wondering, it is great feedback and David and I keep struggling over the words here and wanting to have it be clean and crisp, not too wordy, but obviously we have got to get the meaning conveyed. Do you think "3-C" does not cover the definition adequately enough?

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

I just...and maybe I'm being...

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

I know you've had probably all of 10 minutes to read it, so I...we apologize for that.

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

I'm being too detailed about it but you look at point 2, right, recommendation 2 and you say, coordinated architecture, public API, DSN, core data services, core data profiles, then you go to the back and you have the technical appendix and you only list three of those five. So, I just...because and I get caught up on the DSN thing because outside some people may pick this up and think, well is that an HIE? Is that not? And I know we know what it is, or at least some of these, I mean I wouldn't be the first to tell you I know exactly what a DSN means, but I just think more clarity on that concept is the one thing that I took away when I read through it this morning.

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

Okay.

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

(Indiscernible)

Larry Wolf – Health IT Strategist – Kindred Healthcare

This is Larry Wolf, I wonder if that go lost in the appendix because of the way the numbering runs, if the heading for data sharing network somewhere got lost.

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

Yeah, I think you put the DSN...you guys talk about it so much within the document; it's kind of teased out throughout. I think it needs to be called out as a separate thing that's very linear, similar to how you think about the coordinated architecture appendix and how you think about public API definition.

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

Yeah, it used to be in there. I think that may have...that may be something that got flipped out because there was something more concrete about it. But what about...let me just bounce the notion of a data sharing agreement...

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

No.

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

...like a broader set. So, Deven, I...

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

Yeah, this is Deven, I would not use the word agreement because that assumes a legal...that there is a signed agreement, like a legal document, which may or may not be present in any sort of data sharing arrangement.

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

David, I actually really like the way, and maybe it's just me, but I like what you said about what a DSN is and I actually think a DSN can hold weight in the industry as it evolves to next generation concepts, personally. Not that I had another...not that we all need another acronym in the industry, but it denotes something very different, in my opinion, than an HIE.

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

Yeah, and we intend it to be something much broader than an HIE. I mean, like I said, a plug in framework is a DSN, I mean a list of certified Apps that a vendor is willing to accept and plug in based on well-defined certification tests, that could be a DSN.

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

Yeah, I love it because then the vendor could pick that up, as you're stating, and then say, hey listen, this is our DSN network wrapped around our transaction system and this is how we interop with the regs, etcetera, etcetera.

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

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

Yeah.

Wes Rishel – Independent Consultant

Wes here, what about data sharing arrangement? I thought...I think that as a phrase would highlight the non-technical, non-infrastructure issues, which we have found as we progressively try to implement protocols nationwide, is a real issue.

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

Deven, does that trigger any negative...

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

No, no, it doesn't, in fact, I used it in saying that we're talking about arrangements, we're not really talking about agreements, because that...the latter connotes specific...

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

Yeah.

Wes Rishel – Independent Consultant

Yeah, yeah, this is Deven's idea, I just picked it up.

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

Oh, okay. Well, if it's Deven's idea, we've got to keep it.

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

If Deven and Wes agree on something, that's a plus. I agree with you a lot, but there you go.

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

The point's not to replace DSN though is it because sorry, it's Keith again, I'm being a little snickety on this one, which is I think, maybe I'm a step up, ahead on this stuff is, if this actually takes hold, you got to have structural frameworks that multiple people can glom on to, not just an open API framework, but then a mechanical thing that everybody, including all the providers, can understand from each flavor of a vendor or whether it's CommonWell, whether it's, you know, whatever have you. So I think we've got to be really careful here to not just tweak the word.

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

Yeah, no I think the definition needs to be made clearer in the technical section. I honestly think maybe something got lost in the editing process, because we did have a definition for it.

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

Right.

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

And we need to define it more clearly, so maybe the compromise is to say in this document, data sharing network defines a data sharing arrangement that includes the following things, blah, blah, blah, and just...

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

I agree with that.

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

...make it clear that we're not...so we don't have to go and wholesale cut, copy, paste into a new term, but we can just make it clear that the network is actually just an agreement for data sharing and it could be batch uploads is a data sharing network by that definition.

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

Yeah, I...this is Micky, can we just...can we on the screen, could we jump up to page 9, at the bottom of page 9, beginning with "C," the role of data sharing networks. I just want to make sure that we all are in agreement that this definition doesn't cover it because we need to land this thing and I hate to start going back and thinking that we don't have something in here when it may actually be in here, but we just haven't given all of you a chance to really look at the document in full.

So if we go down...let's see, yeah, so if we go down to "C," that's where we start with the role of data sharing networks, introduce the notion of networks creating business and technical solutions. So this is now maybe where we introduce the term of the data sharing arrangement and then we describe what these DSNs would do in terms of their roles within the DSN, as well as cross-DSN. And we thought it was useful to parse those two things out because there seemed to be sort of confusion around those points as well.

And then for each of those we note that there is a technical component, which I think is getting a little bit at what you're talking about Keith, that there's sort of a structure and a set of mechanisms and perhaps some infrastructure that actually is a part of facilitating exchange within a DSN among those who participate and are exposing public API according to a certain set of rules and integrating with whatever technology the DSN offers. And then there's a policy component that I think of as the arrangement side of what we're talking about here. But, let me make sure if everyone is on agreement on that.

So maybe if we could scroll up now to the next page, this is within the DSN, we talk about the technical component and the policy component and then across DSNs. So let me just go back and ask Keith, Keith, does this cover some of your concerns about lack of definition or is there still something missing here.

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

Yeah it does and I don't want anybody to take this the wrong way when I say it, my worry...I think it's fine, I'm not trying to re-label the term but my worry is people have a certain connotation of what an HIE is and isn't, that was the only point I was really trying to make is if we're just trying to mask that it's HIE 2.0, which includes adopting open APIs, I think this is a different animal. And it doesn't mean that Micky, to the stuff that...I don't know, I've got to keep reading it, so...I think it's here, I just...I may have tweaks on the language.

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

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

I get your point...I agree, especially with like point 2, right, that HIE networks that adopt public APIs will be designated as DSNs in the coordinated architecture, that make sense to me.

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

And I think when we present this next week, one of the things we'll do at the beginning is kind of try to define these terms and we'll be...I think we'll make sure that the data sharing network term is defined appropriately. So the current definition, which is in major paragraph 2 is... 2-C, is that data sharing network, an interoperable network whose participants have established the legal and business frameworks necessary for data sharing. In this document the data sharing networks designated by DSN are those that conform to the coordinated architecture and use the public API. So maybe we need to say a data sharing arrangement whose participants have established a legal and business frameworks, to take that network word and make sure it's clear that it's just the arrangement that we're talking about here. So I think if we get the definition right, we hopefully will relieve some of these issues.

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

I think that's right and the only point I was trying to get at is, on the HIE front is, people have something, they have an image in their head, right or wrong, given the past almost decade of it and in a public setting, I just want to make sure we can delineate clearly what the differences are between a DSN and an HIE.

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

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

Yeah.

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

And they may intersect with certain organizations, all right, just like HIPPS, some existing organizations that call themselves HIEs may also be HIPPS, they could also be DSNs, but they don't have to be.

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

Yeah.

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

Right. It's a really good point and I think if you took it that way, other people who haven't been following along will take it that way so, we need to make sure that language...

Wes Rishel – Independent Consultant

Question.

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

Wes.

Wes Rishel – Independent Consultant

We...are we assuming or should our readers assume that a data sharing network is always represented by a corporate entity in the sense that an HIE is or could just an ad hoc set of agreements among a set of participants comprise a data sharing network?

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

My guess, my bet is that as long as the arrangement meets the legal requirements for moving PHI around, you're okay.

Wes Rishel – Independent Consultant

Yeah, then in that case, I kind of share Keith's concern that the language is leading readers to the assumption that we're talking about a thousand flowers all of which are species of HIEs here.

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

Right.

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

But we are talking about a thousand uses of the public API, many of which we aren't...

Wes Rishel – Independent Consultant

I got a little eloquent there, I'm sorry, I didn't mean to interact. A lot of people are going to assume...make...create assumptions based upon their experience with HIEs.

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

Right. Well, we do have a clarifying bullet I think in the preceding section that noted that we don't assume that the coordinated architecture is an entity or a specific infrastructure implementation. Perhaps we want to do the same thing here with the DSN.

Wes Rishel – Independent Consultant

I hate to add, but I think the concern, oh look, it's the old guys just trying to do the old things all over again, I think is, it's worth our being a little defensive here.

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

I agree.

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

Yeah, it's odd that everybody's taking it that way, I guess I...we didn't craft the language quite right, although we have hopped around today and not built...we haven't built the argument from the principles up, because it would take too long.

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

Okay, so it sounds like adding a paragraph on that that is roughly sort of parallel with the same caveat that we put on the CA would be useful here, that makes sense.

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

Yeah. So, we were working through number 6, I think it was 6, yeah.

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

Yeah, so back to Arien's point is about the last two. Yup, we have Arien's points on the last two about those being sort of perhaps different in flavor so maybe you want to just separate those or distinguish those in some way. Are there other comments or thoughts on this?

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

Well it is, I think this whole section could be reframed to make it more explicit in the beginning what we're actually asking ONC to do. And it's a long list, is there a subset list that are the strong recommendations for policy?

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

Yeah, that's a good point. I mean I think that the strong recommendations are really in one as it relates to Meaningful Use, about specific actions...

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

Um hmm.

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

...and then, I agree with you, this is more of a look here's a spectrum of things that you could do without being explicit...explicitly saying you should do. Is that kind of the point that your making?

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

That's exactly the point, yeah, so I always put on the hat of the policymakers reading this and saying, are they telling me to do something and is there one thing that they're telling me to do, one or two things that are in my control to do that they're telling me to do.

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

Yup.

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

Well those were in number one, that's why we moved that up to number one, had great suggestion from the last call, the one we...

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

So this section is just a, other tools for policymakers to consider section.

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

Yes, other tools and it introduces the notion of monitoring, which is not something done well today, as you know.

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

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

It's hard to argue whether...

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

Go ahead David, sorry.

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

No, I was just going to say it's hard to argue whether Meaningful Use is succeeding or not because depending on who you ask, there are bazillions of messages flowing wonderfully or there are not messages flowing anywhere because we don't really have a standard way to monitor it.

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

Right.

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

And so we're trying to get that notion on the table and then throw in a whole bunch of other things.

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

Yeah so I'd say look, if the one point is monitoring, then elevate that one point and then put in an "other things for policymakers to consider" section.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, this is Larry Wolf; I want to reinforce that notion of monitoring would be really good. I thought we have a lot of backward looking measures and if we could get things that are more real-time to get a sense of how much is flowing and what is flowing and if some of that could get baked into the infrastructure that would be really terrific.

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

Could we scroll the screen down to that...this section? Because I think that this is a great point, is it one of the things that we are sort of...we are strongly recommending here is non-regulatory steps. So I agree with you, we're in this weird in-between where on the one hand we're trying to make a clear demarcation that says, don't jump to regulation, here are some things you could do without saying here are the things that you should do. And we're leaving open that sort of begs the question of, we actually think you should do some of them, but we're not being explicit about which things you should do.

I thought on the last call Gayle and Larry Wolf did express sort of that we should be a little bit more assertive here in the recommendations about the government needing to take some action. I don't know if monitoring and I thought that the issue of sort of guidelines came up then as well, but I don't know if Gayle's on the call or Larry, if you have further thoughts on that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, it's Larry Wolf, I'll jump in. So, the monitoring piece I really like, I think it's a key thing. ONC has baked that into some of its current contracts although it's not clear the data they're getting is always helpful to understand what's being implemented, so that itself takes some tweaking. But I think that notion of getting stats on operational use would be really helpful to a lot of us, because we're in a time of change.

The other thing I really like about this section is it's really completely free of Meaningful Use, it's talking broadly about sort of what government can do and I think that's consistent with what we've been hearing from ONC which is, they're thinking very much about a post-Meaningful Use world and what can they do to support innovation and improve the national objectives or achieve the national objectives with interoperability as one of the very high things that they want to see happen. So, I really like this and I've actually been thinking back to our earlier discussions about MU3 and I think for me the message is we want a really aggressive timeline but how it shows up in regulation is going to have to depend on how those regulations roll out and maybe we should explicitly decouple those.

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

Right. So, I've got to admit when I was writing this section, I wasn't...I was being probably too loose with the language, because I did have in my mind that we were saying that the government should do...should be acting on these seven dimensions in some way. The...number six says, ONC should assertively monitor the progress of exchange across data sharing networks and implement carefully crafted, non-regulatory steps. But then the confusion gets sort of injected here when on "E," so the main point says "should" and then on "E" it says "can," so there's a little bit of a sort of a conflict there.

Wes Rishel – Independent Consultant

This is Wes and I don't know whether I'm being ultra-paranoid here but would you consider adding some language this is monitoring the usage as opposed to monitoring the contents of the networks? I mean, it's just...

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

Yeah.

Wes Rishel – Independent Consultant

...there are...it's a very sensitive issue that people pick up on.

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

Right, right. ONC should subcontract this to the NSA...

Wes Rishel – Independent Consultant

No, I think they just have to task it, I don't they have to subcontract it.

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

Although...this is Josh, I would leave open the possibility of monitoring for data quality, in other words, asking network participants to perform certain analytics to indicate things like whether their data are being well coded and other sensible things are going over the wire or nonsense. This has been a problem in the CDA world for sure.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Anything that helps us get a handle on data quality and measuring data quality would be really useful and I think to do that in a way that doesn’t violate privacy would be really essential.

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

That seems to be a different point though, it seems to be one of the essential roles of a data sharing network is to, not necessarily that ONC should mandate the data sharing network should.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Good point, good point.

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

Right. How would people feel about if we said that ONC should do 1, 2 and 3, which is transparency, guidance and convening...and the convening function and that it can take 4 and 5 as actions to help to sort of cultivate DSNs. And then I think to Arien’s point, 6 and 7 we can sort of break out as being here’s actions that it can take to help to sort of nurture APIs? But we make 1, 2 and 3 as should.

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

I like it.

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

Yeah, you might consider breaking out the level E point about what steps federal government can take, break that down into three so you can regroup them.

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

Yup. Okay.

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

Do we want to carve the monitoring out to its own high level point or is it okay to keep it in this one?

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

I would suggest that we break it...that we keep it with the first three, so we have sort of a three...

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

Okay.

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

...groupings. Because those are all...sort of things, these are three things that ONC should do.

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

Okay. If you have a mental model of how you want to restructure it, I’m happy with that. I just think that we...

Larry Wolf – Health IT Strategist – Kindred Healthcare

So in the discussion...

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

Go ahead.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sorry, it's Larry Wolf. So the discussion about contracting this or tasking this to NSA is monitor the right word?

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

Surveil?

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

What we're wanting to do, I think, is get data on...get anonymized data on usage or de-identified data on usage.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, that's what we want.

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

Yup.

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

I think maybe we should just say that, yeah.

Larry Wolf – Health IT Strategist – Kindred Healthcare

We want...

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

Then we have the current war of PowerPoint as to whose network is exchanging more data and we don't know what it means, but I think part of it is come up with a definition of what useful interchange means and then go get anonymous statistics on how well it's occurring or how pervasively it's occurring or maybe more important, where it's not occurring, but that...more granular background.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, sometimes I think that those worrying whose doing more exchange is...it's all the reflective exchange and nobody else is exchanging.

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

Right, right. That's why we need...part of the process is to define what the heck you mean by exchange in interoperability and that's not a trivial question, I mean from the position of...from the physician's point of view, it's probably simply, did you have access to the data that you needed for this encounter, period. But what does that mean in terms of assessing interoperability, which is a more narrow question. So we're not...

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

That is a great point, the EPIC to EPIC exchange provides significant value for the physician and that shouldn't be, you know, kudos, but it is, however, different from cross-vendor exchange, which is...may just have the same utility to physicians, but belongs in a different space. And I agree with you, it's important to create the ontology and categorize this so that we can at least have the data and context to understand what the numbers mean without necessarily all the spin, but you'll never get rid of all the politics. I just want to endorse that point, I think it's not just collect usage, it's also collect usage and a framework for evaluating volume of exchange.

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

Yup.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Do we have an implied utility here or we don't care?

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

Hmm, I believe that the utility should be from the providers...ahhh, it's so complicated.

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

Yeah.

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

I think quite complicated, too.

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

It is very complicated, we thought about it internally a lot. I mean one thing that we can toss to the architecture committee, Arien, that we can just pick up is, should there be part of the public API, some notion of hooks that capture the equivalent of a web server log file that could be just a requirement that says this can be purposed for a variety of monitoring, fact gathering...

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

Event hooks, yeah.

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

Yeah, well it's more just a web traffic log, you know, where did your request come from, where did they go to?

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

Sure.

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

How many of them were there?

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

I think Deven's going to say that meta...Deven's going to say that we know now that metadata is almost as privacy intrusive as...

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

Well, agree, so...

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

Well...

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

...that's an issue that has to be...maybe that just gets reported out an aggregate statistic by the data sharing networks, but the data sharing networks at least would be guaranteed to have the raw data that they could go do their statistics against.

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

Sure.

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

Right. I mean, metadata...so this is Deven, so metadata, it's just that historically people have just assumed that it is not as sensitive to content, that distinction has gone away, but it doesn't mean that all metadata.

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

Yeah.

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

Right and you can handle it properly, because the people that have access to the actual raw data can do abstractions. Anyway, we're doing too deep here. Micky, what else do we need to do in the last 15 minutes that we've got? Do we want to look at the summary, the high level summary?

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

Sure, let's, yeah, I think...it feels like we're...and is everyone okay with the regulation paragraph? That's not to say you're okay with regulation, just that you're okay with the regulation paragraph, which basically says, as a backstop, the government should consider direct regulation if the market isn't able...if the market sort of facilitated by this list of should and could and cans, doesn't get us to where we need to be.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, I like that sense that regulation is not the primary thing but is a backstop. I think that's well said.

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

Okay. So, if we go all the way to the top, and I don't know if anyone had a chance to read the summary and I think what...going back to college and grad school days, you always don't leave enough time for the introduction, which tends to be the most important piece of any report, the first thing that people are going to read. So, I don't know if people had...and one of the things I tried to do with this is not have it use...basically be, let me just cut and paste the topic sentence from each paragraph and then string those together and call that the introduction. I tried to make it sort of somewhat synthesized, a little bit more narrative in flow and it's something that someone could read through in four or five paragraphs and get the gist of what we're talking about, what the key points.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, it's Larry Wolf, one typo towards the end...

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

Larry Wolf – Health IT Strategist – Kindred Healthcare

...it says FHIR for certification to support MU Stage 2, I think you meant MU Stage 3.

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

Larry Wolf – Health IT Strategist – Kindred Healthcare

But that will get me...but that's, I'm actually using that as a jumping off point to say, should we actually be decoupling this from the stages and just say, we want a very aggressive timeline for adoption of these standards and embedding in certification. And we know that the MU framework itself is undergoing reconsideration and so we're not going to specifically tie it to an MU stage, other than to say it should move out as quickly as can be done, maintaining some kind of...all the other things we've talked about today about why it can't be done too fast, but needs to be done quickly.

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

Um, what do others think, I mean, our whole recommendation one is sort of focused on the idea that MU Stage 3 isn't everything and we need to appreciate that its one, albeit it lever that's...but its unique.

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

I thought it was first on our list not because it's the most important but because it's the most urgent.

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

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

And I do endorse Larry's point that we should explicitly call out that urgency but also not our call for additional...a broader set of tools.

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

Okay. Larry, does that cover it? I...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah, that would be good.

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

...agree with the sense...I think it is important to keep that part of the urgency, I think that's well said, Arien.

Larry Wolf – Health IT Strategist – Kindred Healthcare

My concern is that in January the NPRM for Stage 3 is going to come out and I don't want to get caught in that buzz saw.

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

Yeah. Now we did, we talked about this in our last call and one of the things that we did to try to...you know, we aren't very explicit about saying that something should actually be done here, but I think somewhere, and I forget where it is, we did put in something that I think reflected one of the things we were saying on the call which is that the timing of this is awkward and if that means that we need to sort of adjust the Meaningful Use Stage 3 rulemaking process, that that may be something that we have to consider. So, it's...

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

You know...

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

...if we think it's important enough, we shouldn't take that as a given that January the final rule comes out and that's it.

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

Yeah Micky, one of the...in the hour that you missed, we went deep on that question and there was general consensus that we need to insert some language around exploring the potential for delaying MU3...

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

Oh, okay.

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

...in order to allow time for this transition and for the maturing of the standard and the transition to deploy the certification test.

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

Yup.

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

So, it was a complicated discussion but we delay and/or the word stagger, we will find a way to work that in.

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

Okay. Great.

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

This is the other Larry.

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

Yup.

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

You've got in that same paragraph that the other other Larry was trying to edit, when you talk about XDS, XCA are mature but inherently limited and I feel a little uncomfortable with that inherently limited statement. And it may offend a bunch of people and I'm wondering if changing the word limited to complex may be more appropriate or some other verbiage that Wes could suggest.

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

Well, this is David, the limited was with respect to being document only, it was not so much the complexity that the problem is, that it doesn't do anything but documents.

Wes Rishel – Independent Consultant

So why not call that out specifically then?

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

Limited to documents? How about that?

Wes Rishel – Independent Consultant

Yeah.

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

Okay.

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

Yeah, why don't we do that.

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

Potentially, but on the other hand, if these are CDA documents, they do have discrete data in them, so you have to be careful there.

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

Yeah, we go into deep on...I mean in our...in the other points that we haven't reviewed on this call, we do address the distinction between how that's useful for certain purposes but it's not very useful for high bandwidth exchange, it's not useful for plug ins, for example. The process of producing a CDA in most vendor systems is cumbersome, slow and not appropriate for API usage. The data is there, but it's not useful in the way that APIs can be useful.

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

So Micky, we need a thing that reflects that.

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

Well we capture it elsewhere, I mean in a lot of detail elsewhere we talk about the value of CDA and the value of document-based exchange, but the JASONs called out the limits of it as well and we're agreeing with those limits.

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

Right.

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

Okay.

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

But I think it's a good point that we just need to sort of qualify that we're talk...that the limitation is about documents, about the document only part, so we can add that.

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

Okay.

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

Okay, any other thoughts on the introduction here? I know again, we...try as we might, we didn't give you enough time to be able to read the whole thing thoroughly and but if you do have a chance, I think, David, I don't know if we are going to try to ask people to look at the document more thoroughly and then give us any comments back by close of business Friday, any line item comments or any other comments and then we'll try to wrap it up because we need to get it to the ONC staff, I'm going to guess by Tuesday.

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

No, we need it sooner for this meeting, sorry.

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

I knew you were going to say that, I was just beginning my negotiation.

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

Yeah. So Micky, to your question...this is David, I did mention that, but you just said it again so I think...at the top of the call I mentioned that though if you want to, if you have time to go through the important recommendations and line item things that you want to call attention to, put it in redline mode and send it to us and we'll do our best to accommodate, particularly if there are just egregious mistakes where we got something, punctuation wrong or spelling wrong or numbering wrong. And we do need it as quickly as possible, Friday.

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

Okay. Great. Is there anything else, any other concerns people have, questions? I think I want to thank everyone for what's been sort of a very complex set of discussions that I think got us to a really good place. So, just want to thank everyone for all of your diligence and engagement on what I think have been really terrific calls as well and also I want to thank David, who I've really enjoyed working with on this and hope to do more of the same in the future.

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

Yeah and I'll echo that, it's great to work with all of you all, the comments have been terrific, the process has been demanding, but I think this is useful output. I feel...I've done a lot of these workgroups and this feels like a useful exercise and I think there's a potential that it shifts the discussion in a direction that we'll all benefit from in the long run, hopefully, but, many miles to go. Do we want to do public comment?

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

Public Comment

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

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 at this time so, just to echo Micky and David's points, thank you all for working so diligently over the summer. We greatly appreciate it and we look forward to Micky and David's final presentation next week. Thank you everyone and we'll follow up with an email with when things will be due for feedback.

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

Great. Thank you.

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

Thanks everybody.

Public Comment Received During the Meeting

1. Agree with the comment just made - EP's and EH's are struggling to meet their transmit measures because the vendors capabilities to receive is limited, non-existent, or not yet rolled out for their users.
2. I have substantial concerns regarding several sections in today's draft of the JTF report. Additionally, I am concerned by the uncritical acceptance of FHIR on several calls and in the appendix, in a way that will stifle other innovative approaches such as ONC's structured data capture (SDC) initiative. I've made several verbal and written comments at the end of some sessions, but none of those comments were discussed, published, or addressed in writing. Others have made similar comments, which also were not addressed. How can we submit comments that will be properly addressed and made publically available by the Policy Committee? I need to leave the call at 9 AM ET, so please email me at rmoldwi@cap.org. (From Richard Moldwin, MD, PhD, College of American Pathologists.)