



HIT Standards Committee NwHIN Power Team Transcript May 9, 2014

Presentation

Operator

Thank you. All lines are now bridged.

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

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

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

I'm here.

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

Hi, Dixie. Dave McCallie?

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

Here.

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

Hi, Dave. Arien Malec? Cris Ross? Jitin Asnaani? Josh Mandel?

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

Here.

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

Hi, Josh. Keith Figlioli?

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

Here.

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

Hi, Keith. Keith Boone? Kevin Brady?

Kevin Brady, MS – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology

Here.

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

Hi, Kevin. Ollie Gray? Wes Rishel?

Wes Rishel – Independent Consultant

Here.

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

Hi, Wes. And from ONC do we have Debbie Bucci?

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

Here.

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

Hi, Debbie. And Kory Mertz?

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

Here.

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

Hi, Kory. And Micky Tripathi has joined us from the IE Workgroup as well. So with that –

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

And Arien Malec's here.

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

Hi Arien, thank you.

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

And with that, I'll turn it back to you Dixie and David.

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

Hey, Matthew Rahn from ONC is here as well.

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

Thanks, Matthew.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Okay, thank you all very much for joining us today. Especially thanks to Micky Tripathi for joining us today. This is a very, very important discussion that we're having today, because it really sets the stage for all of the tasking that the Power Team has been assigned for 2014. All three of the tasks that we were assigned, actually to be completed by July, had their origins in the Information Exchange Workgroup of the HIT Policy Committee, which I understand that Micky leads. So Micky will talk to us about the thinking that went behind the recommendations that then went forward to ONC and came back to us – to this Power Team as specific tasking. So, listen through, we wanted to listen through the – Micky's presentation and then we'll have plenty of time at the end to ask questions and just to be clear, the real objective is to really gain a thorough understanding so that the recommendations that we do come up with are responsive to the intent of the tasking. David, do you want to ask – add anything there?

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

No, I think that's a great summary, we're anxious to learn as much as we can. I don't know if we're going to be able to withhold our questions until the end, but we'll see how that plays out.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Yeah, that's a good point. Why don't we see how it plays out and if there are – we don't want to get sidetracked, in other words, but if there are clarifying questions as we go along, I hope you'll feel free to ask them and David and I will manage it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Dixie and David.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sorry, this is Cris Ross, just saying I joined.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Oh, I'm glad you were able to join, Cris.

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

Hi, Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I can only be here for the first hour, I apologize, but I'm looking forward to this.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Okay, good, good. Okay, Micky, with that we'll turn this over to you.

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

Okay, great. Thanks. And this is all sort of in the category of, oh my God; someone's going to try to do what we recommended? I'm just joking. So, thanks for the opportunity to describe our recommendations. A couple of sort of preview comments, a number of them were made a while ago and so we should all just sort of recognize, and I haven't – I'm not speaking about anything in particular here.

It just occurs to me that during the discussion, the markets move, technologies move, policies move and we may want to have a conversation about if there's anything here that strikes any of you as being things that are different now or that were based on assumptions that seemed reasonable back then, but may not be now. I'm happy to have that conversation and discuss it, but just wanted to point out that these were recommendations that were made probably a year ago, I think, weren't they Kory? Or at least last summer. So, except for one thing, Kory Mertz has been excellent support for us from ONC, is on the line. And there are a number of people like Arien Malec who's on the IE Workgroup as well and Dave McCallie, who's on the Privacy & Security Tiger Team, some of what I'm going to describe is sort of a direct overlap with recommendations that came out of the Privacy & Security Tiger Team. So, please feel free to refine or jump in for any extra color as I'm going through this.

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

Micky?

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

Yu.

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

This is David. On – just a question on what you just said, so I make sure I understand it. There has been, I believe, something of a formal recommendation from the Policy Committee about MU3. But you're saying these may not be in sync with that or –

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

No, no, no, I'm not saying that. I'm just saying that there – that the recommendations absolutely from the Policy Committee and so I shouldn't – I'm not trying to backtrack from those, I'm just recognizing that this is a very fast moving area and those recommendations I think were made last summer, if I'm not mistaken. I just forget the timing of it. It feels like it was a while ago, so I'm just recognizing that things are moving very fast and so it wouldn't surprise me to have a conversation now where we sort of recognize that the world has moved and that certain things may be – may bear further reflection.

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

Thank you.

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

But these are absolutely approved from the Policy Committee, what I'm going to be presenting to you is exactly what was approved by the Policy Committee and we obviously stand behind all of it.

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

Micky, this is Arien. One confusion that I've had in the process, and I'm wondering whether you could clarify is we had a set of recommendations that came up through the Meaningful Use Workgroup and were approved by the Policy Committee. And a set of recommendations that we put together at the IE Workgroup and were approved by the Policy Committee. Is the sum of i – is there one place where there the sum of the Meaningful Use Stage 3 recommendations from the Policy Committee? Because I –

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

Yeah, so Arien, this is Michelle. Just to clarify, so what ended up happening due to timing and things like that, so the IE Workgroup, the Quality Measures Workgroup and actually the Privacy & Security Tiger Team, in addition to the Meaningful Use Workgroup all had MU3 recommendations? Some of the timing was not all the same, so as Micky said, the three different recommendations, some of them were in the summer, but the final package of IE Workgroup recommendations were actually approved in November. But, all of the MU3 recommendations were finally approved in April. So if you go out to the healthit.gov website, for example, there's a package of MU3 recommendations that include MU Workgroup, Privacy & Security Tiger Team, IE Workgroup and Quality Measures.

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

Okay, so that's the omnibus Policy Committee set of recommendations.

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

Yes.

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

Great, thank you.

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

And so this is David. Again, some of this will matter in terms of energy and priority, I think, so I apologize for pushing on it but, that omnibus is what will deter – should probably determine our prioritization efforts, is that right? Does that make sense in terms of; there may be things in Micky's presentation that didn't make it into that omnibus?

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

No, all of the things from Micky's presentation are part of the final...

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

Are in that.

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

– recommendations –

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

Yup.

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

– that were approved its part of MU3.

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

Right, I'm only talking about things that were approved by the Policy Committee.

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

Yeah, I couldn't find some of them, so maybe I was looking in the wrong omnibus. But anyway, go ahead.

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

Okay, so I'll send out the complete set where you can find everyone's, to avoid the confusion.

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

Okay, great. Shall we move to the first slide? So I'll walk through three. So there are three specific domains with respect to recommendations, there's query exchange, provider directory and the provider data migration and patient portability, which is about data portability in general. Next slide, please.

So general background, we had these three issues that we were asked to look at. We put some comments into that Request for Comment that I think it was – technically, wasn't that a Meaningful Use Workgroup Request for Comment that I think was put out there for public comment. We got back a variety of comments in these three areas. And on reflection of that, taking that into account and then looking at everything that had happened since we made the recommendations, and where we were when we started to reconsider this after we got the comments, we just made a couple of background notes that we presented to the Policy Committee just to lay some context.

So first, that the market is incredibly dynamic and the landscape looked different, even when we were looking at it at the time, than when we had put together the original proposals that were put into the Request for Comment, the public Request for comment. So in particular, demand for cross-vendor query exchange appeared to be growing, and is still growing with the rapid growth of ACOs. Though also pointing out that there – though there are some channels of query exchange emerging in the market, such capabilities really seemed to not have a whole lot of uptake in particular, the supply really isn't really keeping pace with demand, in general.

As far as directed exchange that's required for Stage 2 starting to take shape. Again, these are slides that were presented last year. The role and function of HISPs at the time, and still I think in many ways is still quite murky and what we were seeing in the market was that a lack of standards for provider directories and security certificates in particular appeared to be an obstacle to more rapid progress. That was just an observation we were making as a workgroup, looking out at the market. We're not addressing the security certificate issue; I believe that Dixie, I don't know if it's in this workgroup or another one, has been looking at that. So we'd specifically noted that that's being looked at somewhere else and that we weren't going to touch on that at all.

Also noted that industry projections, I mean at the time, I don't know if that's changed any, suggested that something like 25-30%, whether the number is right or wrong doesn't matter. I think it's a substantial, non-trivial percent of physicians would probably be in the position of having to change EHR systems in the near future, making data portability an important issue in the market. And then finally just noting that demand for patient engagement is growing in general. This was really with an eye toward just trying to understand all the various dynamics that could affect any IE Workgroup considerations. Next slide, please. So, diving into query, and I'll walk through each of these one by one and happy to answer questions along the way. Next slide please.

So, the sta – we got – you may recall – so we had some comments from the Standards Committee and public comments that suggested that the query for patient record approach that was in the RFC should be simplified and generalized. So we had something that we put there, it wasn't sort of a formal proposal, it was really what we were driving toward was to get some kind of initial like consensus view from the IE Workgroup that could be put into the Request for Comment as really a way to get – to elicit reaction. And so the comments that we got back and the Standards Committee had also, I think at some point, I forget exactly through what channel. I don't know if it was just in a discussion of the Standards Committee, had also provided some comments that suggested a couple of things that sort of resonated with what we were seeing in the public comments.

First, that what was in that initial Request for Comment had a complex set of back and forth transactions that implied some very specific workflow that would be required in order for that to be sort of appropriately taken up in the market. And so the back and forth transaction nature of it, that it was not just sort of the parsimony kind of principle you would want to have, as how do we do this in the minimal set of transactions not requiring a lot of back and forth. And then how do you do it in a way that doesn't imply or assume some very specific user workflow. So, we took that feedback and started to think more about it.

And one of the things that we noted is that the query exchange is occurring in parts of the market where there is third party governance to address policy, legal and technical complexities, thinking about HIE as the noun, in this case, where the examples were Healthway, selected state, regional and private HIE activities. But that – and that single vendor query exchange solutions are growing rapidly as well, you think about Care Everywhere and the EHX EH – the eClinical – and the things that Cerner's doing and lots of single vendor query exchange across legal institutions that was happening as well. But our focus was going to be on recommendations that would enable query exchanges through existing – leveraging existing HITECH authority and not assuming that we would have separate authority to regulate HISPs, HIE organizations or other third party actors.

So we focused specifically on – now this provider directory comment – was this, Kory, I'm just asking, is this a misplaced bullet here? I'm just wondering why the provider directory thing is here.

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

I'm not sure Micky that was from the original set, I didn't add it.

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

Okay, right. Okay. So anyway, the focus here, and I should say before we dive into the recommendation itself, that I think what we heard from the market feedback that we got, and certainly a strong consensus in the IE Workgroup in particular. And I think what was reflected in the Policy Committee approval of it was that if we're going to have any stake in the ground for Meaningful Use Stage 3 in the way of interoperability that it ought to be about query that we needed to get to something that would enable query exchange in the market. And so that was really sort of at least the core goal that we had in thinking about this. How can we lay some kind of policy stake in the ground that would therefore give sort of the direction to the Standards Committee to come up with a way from a standards perspective that we could bake query exchange into Meaningful Use Stage? So it was really with that sort of underpinning that we proceeded with the recommendation. So let me go to the next slide.

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

Micky?

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

Yup.

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

This is David here. On that last bullet point there, could you translate that into practical terms, if it's done under the authority of HITECH without separate authority to regulate HISPs, HIE or other third party actors. Does that imply that this is direct EHR-to-EHR as unregulated under certification?

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

Right, so – right. So the focus, and I think it'll be on the next slide, is that so what we said is, so let's focus this on what can be accomplished in certification of certified EHR technologies. And whether that actually gets instantiated in the market as an HIE becoming a part of a modular EHR concept, for example, provider directory, just like there are modular CQM solutions out there and others, well then that's fine, however that sort of gets manifested in the market. But that the lever we are going to use is the EHR certification authority under HITECH. And we weren't going to assume that we had authority over HISPs or authority over HIEs that goes beyond that.

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

Thanks.

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

Next slide, please. Mine didn't move, did anyone else's? No, there is goes. So what I'll present is, we had some – what we tried to do is break it out into a clean a statement as we could about the principle that I was talking about, where in this case it was about laying a stake in the ground about query exchange. That Meaningful Use Stage 3 needs to get to query exchange.

And then what we had behind that is sort of further elaboration of what we meant, underlying this, to give a little bit more perspective on what we were thinking. So the clear statement of the recommendation is broken out into two, one is for search for patient information. EHR systems should have the ability to electronically query external EHR systems for patient medical records. And then in terms of being able to respond to such queries from external systems, EHR systems have the ability to electronically respond to electronic queries for patient medical records from external EHR systems.

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

Micky, this is Arien and apologize that this is on a further slide, but I do remember us exhaustively discussing the notion that EHR systems would and should be able to delegate this responsibility to a service provider.

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

Right. So, and what would you mean by a service provider? I vaguely recall that as well.

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

Yeah, so a state-based HIE, CommonWell –

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

Right, right, right.

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

Yeah.

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

Yup, that's right and that relates to the point that I was making in response to David's question, that the idea was that the lever is certification if that ends up getting manifested in the market as another organization gets certified for this particular function, then they could do that. And then through attestation, they could put all that together in the same way they do today, for example, as one way that that could get done. Next slide, please.

So we also laid out some principles that we thought were very important from a policy perspective, as we thought about this. So some of the core principles were one, continuity that to the extent that we already had Stage 1 and Stage 2 approaches and infrastructure for directed exchange, and a lot of effort going behind that that where possible and appropriate, allowing the use of – to be able to leverage those. Both those as well as the use of organized HIE infrastructures where applicable and available, so the idea wasn't to say that that should be a completely binding constraint, but the idea was to have as much continuity as possible so that query exchange was building on those and not coming up with something that was completely new.

Simplification, this was responding to the comment that we got back that the – what we had put into the Request for Comment involved too many back and forth transactions, the assumption that you would have too many of those. So setting in principle again the goal of having query and response meet sort of a parsimony principle of meet the requirements for query and response in a single set of transactions, if possible, or at least the minimal set of transactions. Generalization, be able to accommodate flexibility in use cases, workflows, installed base capabilities, legal policy considerations, recognizing that there is a lot of heterogeneity out in the market.

So, for example, allowing clinical sources to have flexibility in how they respond to requests, not making an assumption that there is a single way of responding to a request when we know that there is a lot of heterogeneity out in the market. And as we know, there's a lot of legal and policy variation across legal entities and states. So we didn't want to have something that presumed that there would be federal presumption over state laws over certain things that we know are certainly not there now and would take a lot of time to get put in place, if ONC decided to try to pursue that path. Next slide, please.

Then from the transactions, we weren't – we were specifically not trying to define a standard or what – or trying to lay out what we think a standard is or choose from among existing standards that are out there. But we did want to sort of lay out what we thought seemed to be key elements of what a standard ought to be addressing. And in part this is just to give a little bit more flesh to the bones as we're going through the policy consideration. Recognizing there's a gray area there, right, at what point are we in the domain of policy and at what point have we sort of crossed the line into sort of setting the parameters of what a standard ought to look like. And so we tried to be very cognizant of that, but one of the things we wanted to do was try to flesh out as much as possible what we were talking about and what our discussions sort of clearly brought forth.

So in terms of the querying systems, what we tried – what we thought was that the things that a standard ought to be able – ought to encompass are the ability to discover address and security credentials of the clinical source. So now I'm querying the other system, present authenticating credentials of the entity. Present patient identifying information. Assert authorization for a specific patient level of request so that the data holding entity has some sense of what the authorization basis is for the request. We saw as optional the ability to indicate what type of information being requested, recognizing that in the current world, very few if any systems have the ability to have that kind of data segmentation that they could i – that there would be a standardized mode of being able to ask for a particular type of information. And importantly, being able to respond with just that type of information.

To be able to securely transmit the query message and be able to log that and this is from that query side. And I should have noted that where we marked with an asterisk areas that are completely aligned with, and indeed really build upon recommendations that came out of the Privacy & Security Tiger Team in past meetings and that had already been approved by the HIT Policy Committee.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Micky, this is Cris.

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

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Just really quickly, was there any sense, I can't recall, and that any of these actions should be mapped to any particular actor?

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

Umm, no, could you elaborate a little bit? I mean there wasn't any sense of – as far – not explicitly certainly. What I don't know is whether there was something implicit in there, then –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I didn't want to derail it, it's maybe a variation of the question that Arien asked. Could this be delegated, for instance, to some service provider is one form of the question? The other one would be, which of these could potentially be the responsibility of an individual who was using the system as opposed to the institution that was providing it?

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

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Those kinds of tasks.

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

And another way – another variant of that is, is there an assumed order in the sequence of these transactions or are these illustrative? So if we could divorce the policy recommendations from the actual, for example, service orchestration and standards support that would be helpful.

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

Right, yeah, and so I don't – so, just to the last question, first, or the last point first. I think that we laid it would this way just because it was logical and it just sort of made sense for our discussion to lay it out this way. There was certainly no presumption that it needed to be orchestrated in this way.

And I think getting to your question, Cris, I guess I would just go back to, if I'm understanding your question correctly, I think the idea here, by leveraging the EHR certification process. How that gets manifested in the market ends up being first the function of how the test scripts get written, as you know on the Implementation Workgroup side and as we've seen in the market.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

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

What ends up happening as we've seen with the transition of care summary requirements, as the CQM requirements, that the way those scripts get written and sort of isolated into separate modules, ends up being sort of a strong determinate of how the market sort of responds to that. In terms of how different companies could form or different service providers could form around different modules and be able to provide those services. So, we weren't trying to dictate how that would happen, just this should be a part of what would be considered a certified EHR technology and then there are later processes that would have to unfold that are really outside of the domain of the Policy Committee.

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

And then Micky, this is me being, unfortunately, on both side of this and embarrassingly discovering areas where I should have caught something on the earlier side of this. What’s confusing on the first transaction is discover address and security credentials of clinical source. In many cases, you need to do it – I won’t get into details, but we just need to be very clear about what the responsibilities are for the service that provides identifying information versus a service that provides clinical information. And we’re really talking about the service that provides identifying information, and maybe this is intended to look at providing the address of where you can find the clinical information.

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

Right, so those could be two different organizations, right, which I think is what you’re getting at.

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

Yup.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, I mean, and I looked at B 1, 2, 3 and maybe 4 as things that could potentially be delegated and maybe should be delegated, like patient matching, in the cloud has some real appeal. So, Micky, these questions are not intended to be damning by nitpicking, and I also understand that you took the effort to try to figure out, don’t go too far from policy and implementation. I guess for the purposes of this conversation, it would be useful by the time we’re done to understand which of these kinds of recommendations have a policy component to them and which ones would the Policy Committee say, well we really don’t care, “A” is as good as “B.” Just so that the Standards Committee doesn’t roll over the intended policy, that’s all I’m trying to tease out.

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

Right. Yeah, I mean, I’m not – certainly not in a position to negotiate any of these for the Policy Committee – critical eye – but I would point out that some of the ones, like the ones that are starred. The Policy Committee has come back a couple of times and approved those, right, so from the Privacy & Security Tiger Team they came in and weighed in on query that was approved by the Policy Committee. Then we came in with providing policy direction for a standard, Policy Committee again approved them.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Well Micky, this is Dixie. When you mention that this came out of the Tiger Team, I do remember this conversation within the Tiger Team and it had to do with locating and requesting, as I recall, requesting clinical data – a patient’s data from one organization to another organization.

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

Um hmm.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

But I don’t ever remember saying it has to be – in the Tiger Team I don’t ever remember having the discussion that it has to be asynchronous transaction. I thought we also discussed that you could have a Direct message sent over and says, I’m Dr. Baker and I need this information for the following reason, and send it as a message over there. And they could look in – they could look it up in their EHR and return the data via Direct, that it did not have to be – I don’t ever recall saying this had to be a single transaction, query versus just a request.

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

Yup, I completely agree. Right, that was not within the purview of the Tiger Team and so the Tiger Team didn't address that. I would say that that additional piece is that principle that I think the IE Workgroup felt pretty strongly about is that for Meaningful Use Stage 3, we should be getting to a point where we are able to have asynchronous transaction set for a query and related response. And so we are building on the policy framework that what the Tiger Team said is important for being able – for one legal entity to request information of another legal entity and get something back. And then we put – wrapped that up and said, and from an IE Workgroup perspective, we believe that that ought to be a part of asynchronous transaction set.

Wes Rishel – Independent Consultant

I'm –

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

So this is Josh Mandel and I'm curious looking through this list of transactions, for how many of these is there really a simplified specification that we think works out in production today that could be pointed to versus how much of this is sort of a speculative wish list of things we would like to develop?

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

That's the Standards Committee job, isn't it? I mean, really, I mean so when we talked – we obviously, we have folks like Arien and Peter DeVault and other folks who are on the policy side. Who help us – help make sure that we are proposing something that is reasonable, without seeing it as our job to absolutely say, this has got the maturity, the adoption and I forget the 5-point framework that Dixie and John Halamka and others have worked on. We didn't go through that exercise because we sort of see that as being clearly in the Standards Committee domain.

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

Yeah, I think –

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

Micky, this is David. Just kind of following on Josh's question, I think some of us are trying to read between the lines of the PowerPoint and we're pinging you for clues to interpret, we need marginalia or something. Because the previous slide said we need something that was simplified and one assumes that means simplified with respect to the current extant technology that solves for this problem. And then you come to this slide and it basically lists out how the current technology works. So it's a little hard for us to understand, does simplified mean, go back to the drawing board standards bodies and make it simpler than the current choices. Or does this current slide, which lists the transactions that are part of the current IEG profiles, pretty much one for one, which one trumps?

Wes Rishel – Independent Consultant

This is Wes. I'm wondering if we're taking too much from the word transactions at the top of this slide.

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

I was just thinking that – yeah, I was just thinking that, Wes. Yup.

Wes Rishel – Independent Consultant

Okay, great.

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

Absolutely.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Well the way –

Wes Rishel – Independent Consultant

So, these are requirements not necessarily specific transactions.

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

Yes, yes and that's our error, so I apologize for that.

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

But, so this is Josh –

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

That's why I was going to ask the question –

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

– articulate, what is being simplified? So how is this different from what we already have in connect today?

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

Which is not simple, but which does do these things.

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

Yeah, so this is Arien and I would propose that as the Standards Committee, we treat this as, desiderata and to the previous questioner, I forget who, that we try to distinguish between hard policy constraints and just vague wish lists. And that we not treat these as specific transactions in a specific order, I guess would be the way that I would read this. And Micky, am I –

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

Yes. No, no, I think that's exactly right, yeah. And I wouldn't – I think we did, I mean Arien, you weigh in if you think I'm misstating this but, we tried not to make this a pie in the sky wish list. I mean, I think that Wes characterizes it right, that transactions is not the right word there, but we saw this as a set of requirements from a policy perspective that a query and response standard would need to be able to encompass. But, it's certainly not about it being a set of transactions and orchestrated in this way, I think that's absolutely.

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

So I won't push this point further, but so I understand this as a set of requirements, not a set of transactions, but what I haven't heard yet is how are these requirements not being met by the technology that's out there today? What's missing? Because otherwise I think there's a risk that the standards group will come back and say, well here's this standard, it already meets your requirements.

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

Oh so no, so again, just remembering the sort of the responsibilities of the Policy Committee versus the Standards Committee, it's not for the Policy Committee to say, Standards Committee, you should use the Connect – all the IHE standards baked into the ConnectSolution as the standard for Meaningful Use Stage 3 query response. Right, that's not the job of the Policy Committee. If the standards – it seems to me, if the Standards Committee comes back and says, that's all met by Connect, so we're going to say that that is what is the standard, well then, fair enough. That's the Standards Committee's job.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

That –

Wes Rishel – Independent Consultant

This is Wes, I think you're – when you combine this with the previous slide and the call for simplification, we're interpreting the call for simplification as a statement that the current Connect is too complex. And I think –

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

Wes Rishel – Independent Consultant
– .and I think –

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

Wes Rishel – Independent Consultant
Go ahead.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative
No, no, go ahead Wes, sorry.

Wes Rishel – Independent Consultant
And it think we have examples in single vendor EHR-to-EHR transactions mediated by the same vendor that although fairly simplified workflow and set of apparent transactions to the user, would you like me to get your medical records from “X?” Yes. Okay, the computer does the work and it may be that the idea is that there are work – there are use cases where the mechanics and the separate transactions associated with the Connect process are being compared to relatively simple possibilities in certain circumstances. I’m just trying to make a case for perhaps it’s the combination of simplification and this list of requirements that is the issue that’s being presented to us.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative
Right, right. Yeah, so just on the previous comment about simplification, that was not just for – I would urge you not to try to over-interpret that, that was really – it wasn’t directed at all at Connect. It actually, if anything, it was really just a response to a lot of the comments that we got on the RFC that said that what we had put into the RFC was too complex and involved too much back – an assumption of too much back and forth – too many back and forth transactions. So that’s when we said, all right, well in response to that, we should have as sort of a policy and sort of a core principle of what we’re going to do going forward that it should be as simple as possible. It wasn’t trying to take a shot at Connect and say that that was too complex.

Wes Rishel – Independent Consultant
Well implicitly though, that sequence created a set of comments on Connect, right, that is the RFC described Connect and then we got the comments back.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative
Um hmm. Right. Yeah, I mean I guess you could see it that way. Yup.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
I mean there – this is David. There are many of us who would love to simplify it, but that’s a big deal to start this late in the game. So that’s why we’re being so picky about this, or so –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative
Yeah, no, I understand, yup. Well, I mean, and it seems to be again, just speaking personally, that it’s totally appropriate for the Standards Committee to look at all of this and say that this is a very complex set of things that has to happen. Again, it’s not – they don’t have to be separate transactions, doesn’t have to be orchestrated in this way, but we agree that all of these things have to happen in a query and response and there is a solution already out there and it’s called Connect and that’s the recommendation for Stage 3.

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

And we consistently had the back and forth on do we want to be mobile friendly? Do we want to look at the way that our peers in other industries are engaging in transactions that allow for multiple actors to use and manage the same transactions? Or do we stick to our guns on the stuff that was developed 10 years ago, that's actually out there and some people are kind of using?

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

Yup.

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

That's clearly why our job is fun.

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

Right, right, I mean there are other wrestle approaches and I think that what you just said Arien, underlies every standards conversation, it seems to me.

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

Yeah.

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

So Micky, this is David and maybe you cover this in another slide, but I'm going to change the conversation to the content of the transaction. Do you guys weigh in on what the – is there a policy level expectation of what kind of data is moved back and forth? Does it have to be a CDA document, for example, or is that unspecified at this point?

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

That's unspecified. We remained agnostic on that and that was really sort of going back to one of the principles that we talked about about remaining flexible to the heterogeneity that's out in the market. And for ultimately for the responsibility of the data holding entity to decide what's the appropriate response, based on their own policies and based on the authorization that they've gotten and what they feel is the assurance level that they've gotten for whatever it is they're going to respond with.

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

(Indiscernible)

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

I'm going to challenge that one, though. So Micky, I think now I'm in the uncomfortable position of arguing on both sides of these committees. But, I do think there is an important policy consideration that says, what are the kinds of data that would be most helpful to have ubiquitously available in order to meet our broad level policy goals. And the reason I'm saying that is that we're in a position right now, and we've seen this in some of the work that a number of us have done, that you've got a generalized, you can go query anything kind of transaction.

And it ends up not being that useful when you actually want to know, what's the latest status of this patient? As a distinguished question from, what's the relevant medical history of this patient for disability determination? As a distinguished question from what other imaging tests have been done for this patient so that I can avoid – so that I can request the actual image data and avoid a duplicate test. And those all three actually require some deep dives in terms of the content that you want to exchange. Where an open-ended, go get stuff kind of transaction may not actually meet either the policy goals that we want or the resulting clinical workflow that's necessary in order to more efficiently drive those transactions.

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

Right, and again, I can't speak for the Policy Committee but I think it's fair to say that we'd probably be hard pressed to find anyone on the Policy Committee who would disagree with wanting to have a standardized response that is more clinically relevant. And it is more aligned with the ultimate policy objectives that we want to accomplish as an entire process. I think this was really more with trying to recognize that there is lots of legacy stuff out there and not wanting to set the bar so high that it would be unachievable. The same as –

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

And I guess the – push back though would be, it would be useful if the Policy Committee could put a line in the sand and say, yeah, we want everything, but we want at least these three things.

Wes Rishel – Independent Consultant

I'm worried that we're headed in a direction of demodularizing the security and general workflow requirements from content standards here. In other words, there's been a lot of work in Stage 2 to separate out and talk separately about all of the mechanics of Direct, for example, versus content. And I'm beginning to hear a – I'm worried that the direction that this is taking is towards saying, ah, well, we want this set of technology and security standards to apply to this specific functional capability.

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

Yeah, we definitely need to demod – we definitely need modularized, but in my experience, having an open-ended query for data transaction without also defining at least some subset of well-defined data package that actually meet the clinical need, means that you get query for anything, but nobody can actually receive it and read it.

Wes Rishel – Independent Consultant

Yeah.

M

Right.

Wes Rishel – Independent Consultant

Okay.

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

And this is David. My concern also, or my probing was if the requirement was that a CDA be transferred, for example, then interest in using something like FHIR might be diminished. But if the requirement is unspecified, it just needs to be useful content and you're trying to achieve this simplification goal, you might actually look for something completely different than fine-tuning of Connect. You might look at FHIR or, as Dixie suggested, an automazation around Direct or something. But it sounds like Micky's saying, they didn't specify content one way or the other, so I think that's fine.

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

Right. We could certainly take it back for consideration, as I said, I don't think – directionally I don't think anyone would be opposed to it, I think this was more sort of constraining ourselves, just recognizing that there's a high bar being laid out if we expect to have some kind of standardized response to every query. But, I think that's a practical consideration more than anything else. But I agree with you that would be – that would certainly be the goal.

So, moving ahead in the slides here, the next slide's really just drill down into each of these, I don't know that we need to – we've talked about a lot of these already, so I would suggest that we keep moving, unless anyone has any further questions on the – I think on the – next slide, please. And then this was the one that addressed, Arien, what you were just asking about, where we left it sort of open and agnostic about what they would respond with. And the only requirement that we suggested was that they respond with something, that you had to respond with something, which again is aligned with the Privacy & Security Tiger Team recommendations when they were considering requests from one legal entity to another for clinical data.

So, I think this is the last slide, if I'm not mistaken, on query exchange. I don't know if we want to just move ahead to provider directory and then we could come back if there are any questions, or if we want to take more questions on query exchange, I'm happy to do it either way. Why don't I move ahead.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Yeah, let's move ahead.

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

Okay. So, next slide please. On the provider directory, there was a little bit of history here in that the IE Workgroup, it was at least two years ago, I think, did make some recommendations in response to a request from ONC related to provider directories, which had the idea of entity-level directories, provider-level directories. And that was approved by the Policy Committee and then the Standards Committee, I think, determined that it was infeasible and that the standards, I think, were not mature enough yet for there to be an articulation in Meaningful Use certification requirements. I hope I haven't misstated what the Standards Committee view on that was but it ended up not moving forward.

So we were asked to look at it again, and taking that feedback into account and looking at where the market was, one of the things we noted, as we talked about earlier, was that there – as sort of Direct started to work its way into the market. As the HISPs started to sort of crystallize and started to get a little bit of market traction, there did seem to be, from our perspective in looking at the market, some – a certain amount of barrier to progress based on the lack of standards for provider directories. And we had a concern in the IE Workgroup that as we looked ahead, that that could impeded Stage 3 query exchange as well.

So, the new recommendations that we had, here are the recommendations that got approved, we were calling them new back then, reflect the feedback from the previous, I think that should say HIT – well, from the previous Policy Committee recommendations that then went on to the Standards Committee. And the feedback that we got from the Standards Committee as well as, the market trends that I talked about. So the previous recommendation, like the – sort of in keeping with our approach on the query exchange, at that time it wasn't focused specifically on HITECH statutory and programmatic authority. Which ended up being, I think one problem was that it was hard to figure out exactly what the policy levers would be to implement the recommendations that we were talking about. And it also – those recommendations also were made prior to Direct and all the work related to Direct and Direct being included as a part of the Stage 2 certification.

So the current recommendation focuses solely on enabling provider directory functions within the context of HITECH EHR certification authority, just like the query exchange. And building on market developments as we're seeing them in Direct and query exchange. It again, like the query exchange, does not assume separate authority to regulate HISPs or other organizations. And we also just did note, and this was for the Policy Committee more than anything else, that we had made some recommendations on the CMS ONC RFI on health information exchange that specifically highlighted opportunities to use existing CMS databases, perhaps, to catalyze market adoption of provider directory capabilities. But I don't think that's – that last point, I don't think is relevant to the Standards Committee.

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

And –

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

I have one question, just one question. You said that you were asked to look at this topic again, who asked you to look at it again?

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

I – this is where my memory is going to fail. I thought that we were asked by ONC, but is that not right Kory, or did we decide that we wanted to do this?

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

You guys decided you wanted to include it in the Stage 3 recommendations.

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

Okay, so sorry, I misstated that, we asked ourselves to do this.

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

And I would add here that one of the feedback – one of the pieces of information we learned in the listening session that we did, with respect to current progress in information exchange for Stage 2, was that there was an expressed set of discomfort, which I think was a little theoretical. But at least was actually expressed by a number of participants, that not knowing who else was available to send to, was impeding – currently impeding information exchange.

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

Yup. And we personally are seeing it in the market every day that across HISPs there is no ability right now, there's been no production provider directory integration capabilities that we have seen in the market yet, with our statewide HIE, with all the HISPs we're working with and we're working with a variety of commercial HISPs.

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

And just to add to that I would say that what that manifest itself in the hearing that we had is, I want to send information, but I don't know who to send it to. I don't know who can see the information that I'm sending.

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

Right. And even if I know that they have a Direct address, I have no idea of finding out how to do it.

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

So, this is David. It seems like there's a valid use case there for essentially search for provider and/or specialty at location, etcetera, using sort of common sense fields. And I think we understand that use case from previous discussions that we've had on this subject. What I'm not clear about is what they see as the role for query exchange for these directories? And I guess I'll go ahead and posit that now that you've clarified that you appear to be talking about EHR-to-EHR query as opposed to the use of a third party network, like HealthWay or CommonWell or Surescripts, maybe that's the context in which this query makes sense although I would wonder if, in fact, that's a practical assumption. Because most people are going to go through these third party networks in which case they already have their query mechanisms for certificates. I'm not sure what problem we're solving is, I guess the question here, outside of the provider lookup, the name lookup, yeah, I got that, but –

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

So I guess the general thought was that for any type of transaction that is going to another organization, whether it's a push, a Direct style push or whether I'm directing a query at that organization, I want to have some secure, unambiguous way of knowing that I am sending it to the right place, even if it's a query.

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

Yeah, and that's built into Direct mediated through the HISPs for direct, it's built into the various networks mediated through their particular implementation for HealthWay, CommonWell, Surescripts and the others. In other words, a general-purpose tool is redundant at this point, it seems to me, other than for the lookup, I would grant you the lookup for names.

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

Well I guess I don't understand what you mean by that. I mean, there's nothing certified that would allow that to scale across HISPs or across however that's instantiated in the market.

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

Well –

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

So that's the problem we're trying to solve.

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

Okay, for the directory lookup, if I want to find the cardiologist named McCallie that works at Partners, I agree that you need that use case to be covered.

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

Yup.

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

And that doesn't exist today, is something that – I'm worried – my concern is for the other part of the requirement, on the query exchange and the notion that somehow the public keys are being communicated through this directory service. Because Direct doesn't do it that way and doesn't need it, HealthWay doesn't do it that way and doesn't need it. The vendor-to-vendor mechanisms don't do it that way, and I don't think they need it either. So I'm trying to say, there's one problem here I understand, the second problem I don't understand at all.

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

Okay, so I guess, on the second part, maybe this is more related to, I'm not sure whether you're addressing the query exchange or the provider directory piece of this –

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

Query, the query part – query exchange, yup.

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

Okay, so we're back on query exchange. I guess – so the idea there is that I need to have a mutual strong authentication so they know that both sides are valid and robust, right. I guess I'm not understanding the question there.

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

Yeah, but you wouldn't use HPD Plus or a directory service to do that in today's world. The networks do that with different technologies already. I mean, maybe I'm –

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

Oh sure, yeah –

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

(Indiscernible)

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

The problem is not – the problem that we're trying to solve is not do I trust the end recipient, because we have other mechanisms for doing it. The problem that I expressed at least was, I want to send something, I want to send it to Dr. Smith, but I don't know if Dr. Smith can receive a Direct message and if they can, I don't know what their Direct address is.

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

Arien, for Direct I got it –

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

No –

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

– but what is this provider directories are crucial component of both directed and query exchange? I don't know the role of provider directories in query exchange.

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

So if I want to be able to query Dr. McCallie at Partners Healthcare, then I would want to be able to have some way of understanding the address for Dr. McCallie at Partners Healthcare, right.

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

Yeah, and I guess the issue isn't so much what's the role of it, it is that each of the exchanges that do this, do it in a very different way. So e-Health Exchange has a UD service where you query by OID, where you know the mapping between the OID and the organization you want to query and you get the address of the organization that you want to query. CommonWell embeds the results of the record locator search with the address of the organization that has the record that responds to that record locator search. So we all of us solve for the address – the mapping from location to address or from individual to address problem, but we all do it in a different way.

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

Right.

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

We usually embed it in the transaction set that we're supporting within the network.

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

Got it. Got it, right.

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

And there's one other – this is David, again. There's one other fundamental difference that I must admit I didn't really think about it until just now and clear – in my own head clearly, so maybe that's why my question seemed so ill formed. But with Direct, you're pushing always – almost always, to a specific physician. So far the query implementations have been patient focused to an organization, but not to a specific clinician. In other words, Connect or any reasonable commercial implementation that's derivative of Connect, like Healthway and CommonWell, you query an organization for a patient you don't query a provider.

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

Right. No, I understand, but I mean I still – yeah, so on that particular point, I mean, I still need to know Mass General's address, right?

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

Well –

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

But I understand, I understand that that isn't necessarily something that would be in the provider directory –

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

Exactly.

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

– I think is what I'm hearing. Yeah, and that I totally understand, so I wouldn't – this was a background – if this is a background statement, perhaps we could have gone into greater detail in sort of elucidating how that – how we would break that out, and we didn't have that detailed a discussion. So I think to me, this is a supporting technology for what we want to do, which is query exchange or Direct. And so I guess the way I would think about it is that for that particular exchange, however – as long – however security and authentication is managed along that entire chain of events, as long as it meets the requirement, then it doesn't matter where it's placed. Whether it happened in the provider directory or the provider directory enables it, like it would with Direct, or in some other place as a part of the network transaction for query exchange. That's – so, maybe we sort of were a little bit too narrow in sort of assuming that all of that would happen in a provider directory. So I take that point.

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

Thank you.

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

So –

Wes Rishel – Independent Consultant

This is Wes.

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

Go ahead. Yup.

Wes Rishel – Independent Consultant

I – there was a statement that kind of flew by here that has concern for me and I'm in danger of going out of scope here, if I do, I'll accept the ruling from anyone. The thinking that went into Direct was to create a single, universal way of exchanging information that could be mediated by many organizations, but didn't require a specific organization. And frankly, it was in part motivated by a perceived lack of progress with state-level HIEs across the country, that is, in some cases there has been great progress, in other places, there hadn't. And we lost that.

We are not into a situation where HISPs can't talk to other HISPs because the trust solutions are not common and earlier someone said, well, we have other ways of determining trust, we're just talking about addressing here. And while that statement is formally correct. I think we are in danger of getting the version to Stage 3 and finding that once again, the trust issue and the issues of HIEs finding – using various means to leverage their position to provide a value – to find a value to add, is going to lead to the failure to actually achieve the goal, even though we establish the standards. End of soapbox.

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

Wes, this is David, the only clarification I'd add to your soapbox is, the trust issue isn't a technical failing, it's a policy failing. The technical means for trusting each other are well –

Wes Rishel – Independent Consultant

Yeah, no, I thought having an opportunity to talk with representatives of the Policy Committee might be a good position to get on a soapbox about policy, that's all.

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

Yeah, and I just want to say, it is a policy issue.

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

Okay –

Wes Rishel – Independent Consultant

And I'm not specifically picking on Massachusetts, Micky.

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

Yup, I understand.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

You don't have people – that today. Let's keep going.

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

Yup, next slide please. So again, just another slide on background, that the July Policy Committee, which was last year, last summer, the provider directory recommendation was approved by the Policy Committee, but asked the workgroup to revisit the principle on authentication. In particular there was some concern from the folks who were working on the S&I Framework that some of the recommendations, particularly as it relates to authentication, might not be aligned with the direction that was sort of emerging in the S&I Framework group on provider directories.

So we did have a number of discussions, we had the opportunity to talk to the folks from the S&I Framework and had a couple of workgroup sessions with them. What ended up coming out of it was a reaffirmation of the recommendation to include the capability for authentication, to access – so this is the authentication to access a provider directory. And then further amended the recommendation to also require authentication of the provider directory holding entity, not just the requesting entity. So, after we talked to them, it seemed actually that we had missed one part of the transaction. So in particular the concern was, how do I know if I'm querying a provider directory that I'm not being spoofed by something else – some other entity that's claiming to be the provider directory that I think I'm requesting data from.

So that sort of aligns somewhat with the S&I approach that was already including authentication of the data source, there was the – what the – the part that they were concerned about was the requirement for authentication of the requestor. We, as a workgroup, decided to keep that in because we thought it was pretty important and seemed to be what was happening in the market as well. So the recommendation is solely about the capabilities that certified EHR technology should have. Again, this is – it's not that – we're not recommending any kind of Meaningful Use behavioral requirement that would go along on this, this is a part of the infrastructure underlying some of the other capabilities that could have Meaningful Use attestation requirements associated with them. But there was no Meaningful Use attestation associated requirement that would come from provider directories, per se.

And it was our sense that including the capability in certification gives the maximum flexibility to implementers and policy directors, the provider directory market – and policy makers, sorry. The provider directory market and use cases are still evolving. They were evolving at that time they're still evolving. And – but what we are seeing is the provider directory implementation is utilizing authentication in the market today and so it seemed that we would be missing something that seemed to be important to the market if we didn't include authentication as part of a certification requirement. Whether implementer – whether those in the market who were implementing these solutions end up using those features is sort of up to them.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Micky, this is Dixie.

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

So – yup.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

You said earlier that you thought – you – that some other group, I think you implied that it was the Privacy and Security Workgroup, was addressing security certificates – standards for credentialing certificates? And I don't know of anybody who's doing that, so I –

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

Oh, okay. I was under the impression at the time, I think Dixie that it was a workgroup that you were chairing or co-chairing on the Standards Committee side. I may have been wrong on that.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Well, it would have – I mean, if it's standards, it would be the Privacy and Security Workgroup, but we've not been tasked to do that, we were – the closest thing we were – I mean, we were asked – we did a hearing on NSTIC, but that's more the user, and it's not really digital certificate standards. So I think that, somebody needs to address that as well.

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

Right.

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

And this is David. I think the concern that some of us have on this authentication, the mutual authentication requirement is the policy complexity of these trust frameworks that that would create – would then have to be managed. And given that we've struggled to get that right for Direct, which is about as simple as you can get, the more of those mutual authentication networks that we have to build and manage at a policy level, the harder it is to see this being successful. And I would point out that Direct is designed to make it a don't care, if you don't – if you're not a member of the trust framework, you can't send a Direct message to anybody that's in the trust framework and vice versa. So, the authorization of these directories, at least with respect to direct, does not seem to be critical to me.

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

Right, although I guess – I mean, but what we're seeing in the market is that people are building authentication walls around their provider directories.

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

Well, they're doing that for proprietary business reasons, to charge access. I mean, that's –

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

That's not technology – it's not –

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

(Indiscernible)

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

Well, that's – and I can speak for the Massachusetts HIE, and that's not why the Massachusetts HIE is doing it, it's because the stakeholders have said, I don't expose my directory out into the public in general, why would I allow that through the Mass Hlway?

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

Well, what's in your directory besides Direct addresses?

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

It's – I mean, it's all direct addresses, but it's at the individual level for some organizations, if they choose to do that.

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

Right, but there's nothing anyone could do with that unless they're in the network.

Wes Rishel – Independent Consultant

Well, they could get a list of members, I mean, there's the security and aggregation issue.

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

Yeah, but they could get a list of members from the website of the practice, too.

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

Right. Well, we've not seen it as our role to tell them that they shouldn't worry about exposing things that they are concerned about exposing. We're responding to the market in that case, and it's been sort of a pretty widespread market consensus, at least here in Massachusetts, that they wouldn't want that exposed in the public.

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

Yeah, and I just wonder how much of that is a misunderstanding of how Direct works, but making it a requirement –

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

We're seeing it from the other HISPs, too – I mean no other HISPs allow us free open access and the clear access to their provider directories. I don't know that every single one of them is commercially motivated, I think that a lot of them are motivated by the same things that we're motivated by.

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

Yeah, but those providers – the providers are freely exposed through the MPI service in many websites, I just think it's a misunderstanding. I understand where the fear comes from, but I think the system design to make that not much of an actual threat and the data is available elsewhere anyway.

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

Well, it may be over time people get comfortable with it and they see, but everyone is very cautious right now, I think.

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

Yeah, but if you put in place a requirement for it, then we'll still – we'll create even more of these islands of trust, we'll have a standard, but we'll have islands of trust. So that comes back to the policy side of, how do you put in place a mechanism for widespread swath of providers to trust each other.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

But there's no requirement that they use it, what they're recommending is that it be included in the certification.

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

Right, it's a certification requirement. And the concern that we had of not including that is that then it would become something that wasn't very useful to the market.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Yeah.

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

Yeah, if it's just to certify it and then you turn it off in the real world, that's okay, but it's –

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

That's, right, that's the recommendation here, it's just for certification.

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

It's just extra work that –

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

Yup, understand.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

But it's all in the same protocol.

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

Meeting your customer's needs is just work. Next slide, please. Okay, so a similar structure to the last recommendation, and I know we're getting short on time here, so I'll try to go through quickly. The recommendation is that from a search perspective, the EHR systems have the ability to query external provider directories to discover and consume addressing and security credential information to support directed and query exchange. And I recognize the caveat that we just have that for query exchange, that may not be the way that the market really does that, or from a technical prospective is the best way to do it. And then from a response perspective, EHR systems have the ability to expose the provider directory containing EPs and EH addressing and security credential information to queries from external systems. Again, focusing on EHR systems because we're leveraging the certification authority from HITECH.

Next slide, please. And this, with the same conversation that we had before with the query exchange, how the market ends up instantiating this, these recommendations are agnostic to that, as long as it's certified under the certified regime, you could have different companies doing different things and packaging and repackaging as modules that people build and put together as they see fit. So, again, in the same spirit, we talked about some guidelines.

One is about scope, standards addressing PD transactions that may be, and again, I'll just put in that caveat again about query. The continuity, again that continuity principle of saying, let's try to build on what we've done before and what's out in the market, to the greatest extent possible. Simplification, some of these are very consistent, and then just defining what's an external EHR system, an EHR system another distinct legal entity, regardless of vendor, in the same spirit as the Meaningful Use Stage 2 certification and attestation requirements define.

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

So this is Josh, I'd like to ask a clarifying question about the certification requirement, which you say wouldn't be backed up by an attestation requirement. On the certification side, would a certified EHR product need to expose a provider directory or merely have to be able to consume data from a provider directory or both?

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

The recommendation is both.

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

And this is David, I was afraid you'd say that. Why would an EHR have to expose a provider directory if, in fact, the HISP is hosting the Direct content for them?

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

(Indiscernible)

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

Well this HISP could be, yeah, so again, remember EHR in this context is EHR as defined in the certification approach, which is that a HISP could become certified for the provider – to meet their provider directory requirement. And then one of your customers, David, if Cerner decides not to do this and then there's a HISP, that HISP – can get certified, then your customer would just attest in the market basket with the Cerner EHR and the HISP provider directory.

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

Okay, again I just see implementation complexity if you have thousands of EHR instances hosting directories, you now have the directory of directories problem, because there isn't a federation solution that's been workable proposed.

Wes Rishel – Independent Consultant

So just to be clear –

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

It could – work.

Wes Rishel – Independent Consultant

So, just to be clear, the certification is done by a vendor. HISPs could come in and get a, what we used to call a modular certification for the capability to provide a directory and EHR vendors under some sort of reasonable definition of what an EHR vendor is, might not have to do that themselves. And it is now incumbent on all of the practices to assemble the various certifications they need in order to attest, is that – I'm just reviewing the bidding here, is that correct?

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

This is Arien and if you remember the Meaningful Use the edition 2015 is intending to move towards a world where modular certification is the only certification, so there is no such thing as a complete EHR.

Wes Rishel – Independent Consultant

And, then it's incumbent – all right, yeah, okay. Thanks.

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

Right, so I think again, David just to your comment. I mean we specifically in our – in the previous recommendations that we had going back a couple of years, we did make some recommendations related to trying to address the issue that you're talking about, which is the sort of the proliferation of directories all over the place and the associated issues that would come from that. And what we ran into was the issue of having no authority for being able to do that in a more rational and perhaps hierarchical kind of way. And so that's why we came back and said, well, we've got to focus it on leveraging the existing authorities that are there, which is certification. And hope that the market does this in a way that's going to be efficient, and it doesn't – it's not efficient out of the box, just like in any industry, but hopefully there's efficiency that builds over time. But you need some standards to get that started.

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

Yeah, and this is David, I appreciate that limitation of the number of levers that we have to pull. My thought, and maybe it's not correct, but my thought is that requiring an EHR to be able to query a directory using the standard makes sense, and then let the market figure out who's going to provide those directory services. Rather than requiring every EHR to both present a directory as well as to query it, which seems to me, 95% of the EHRs aren't going to ever actually host a directory, provider practices aren't going to host –

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

What if –

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

Right, but see, I think that's okay, I think it's because, and I think that you're taking too narrow a definition of EHR, I think that in our sense, its EHR technology as certified. So to your point, 90% of what we might call EHR companies today, like Cerner, EPIC, eClinicalWorks, EMDs, may decide that they're not going to do this, and so the providers are going to have to go out and look for certified solutions. And HISPs may say, all right, I'm going to get modular certification for this provider directory function.

Wes Rishel – Independent Consultant

So, but again –

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

What it becomes in practice though is a requirement that the provider participate by purchasing a directory responder, but there's no actual attestation requirement that they be in the directory, am I understanding that right?

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

Yeah, so we didn't, right, we didn't talk about an attestation requirement that they be in the directory.

Wes Rishel – Independent Consultant

So again, okay, no, I guess Arien nailed it, yeah, thanks.

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

Yeah, it's just it's a lot of extra work on the certification side – well, whatever, I won't – never mind, I won't go there.

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

Yeah, I agree, I mean, I agree there's a lot of extra work, but this seems like it's an area that needs a lot of work.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

So, I think we should remember that an EHR module is defined by what the vendor says it's being certified by, so, a vendor could get a module that did nothing but a look-up and didn't provide the directory itself –

Wes Rishel – Independent Consultant

Yeah. But the problem is that every practice now has to get one of those, along with what they thought of before as purchasing an EHR –

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

That's what I was going to say and –

Wes Rishel – Independent Consultant

Okay.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

And, then the onus falls on the buyer to figure that out.

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

Right, but that's not different than what they need to do for transition of care or for –

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

Well the good news here is – its Josh, they don't even have to make them work together, because they don't actually have to use it. They just have to buy it.

Wes Rishel – Independent Consultant

Well, we don't know what the attestation requirements might be, the fact that the Policy Committee didn't –

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

(Indiscernible)

Wes Rishel – Independent Consultant

– yeah, and anyway, just if you heard yesterday's meeting or Wednesday's meeting, just telling the AMA that all their practitioners have to buy another product now, even if they don't use it is a tough row to hoe.

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

Right, well I think the presumption was that this is a core piece of sort of back office infrastructure that is going to be required for other things that are going to be attestation requirements. Right, so the ability to do something meaningful from a clinical or more outcomes perspective related to query and exchange. But I think in principle, we wanted to get away from, and I think as an entire process across both the Policy Committee and the Standards Committee, I think we do want to get away from these kind of check the box infrastructure sort of attestation requirements. You are required to send one of this to someone else, you are required to be in a provider directory. I mean, that's what we were trying to get away from with the presumption that this was going to be a core underpinning of other more meaningful things that were going to come out in the way of attestation.

Again, each of us is working on our own specific piece with the assumption that we're directionally trying to head away from those kinds of infrastructure specific requirements. And that there are going to be some types of requirements related to continuity of care, care planning, all the things that the Meaningful Use Workgroup has been working on, that is going to rely on an underlying capability for directed exchange, query exchange and those in turn would have some reliance on provider directories.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Micky, I think we better move on, we are falling behind at this point.

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

Okay.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Thank you.

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

So why don't I jump ahead then to the last topic, next slide please. So this was, in some ways, actually believe it or not, this was the hardest one in our discussions with the Policy Committee. So, let me move ahead to the next slide. Now this one, Kory, correct me if I'm wrong, I think this one did come from a request from ONC to look at this.

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

Yes.

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

Okay, thank you. I knew there was one. So, this, and just to refresh everyone's memory, there is a requirement for data portability that's in the current 2014 certification requirements. And I think it says something like, I don't have it in front of me and it's been a couple of months since I looked at it. But there is a requirement for I think some type of def – there's a definition of core set of data, and I forget what that is, and that data portability be enabled through CCDs, I think, as the vehicle. And if I'm – I think I'm correct in saying that those two pieces are already in the 2014 certification –

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

This is Josh, that's right, and the data is basically the sort of common data set for Meaningful Use, there's not much more than that, if anything.

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

Okay. Yup. Thanks Josh. So, as we started to think about this and sort of the general question was posed as data portability in the use case seemed to be, at least as presented at first glance, the use case being a provider that's leaving one EHR and moving to another one. And as we started to think about it, we started to tease out what seemed to be two valid use cases, one is the provider data migration problem of switching from one EHR to another. But the other that came up, and I think Arien, you may have been a part of this conversation, which was about patient portability, a patient requesting to move their complete record from one PCP to another, for example.

The goal would be to enable patients who switch providers to have their care continue seamlessly, to enable providers switching EHR systems to continue providing seamless care to patients. And one of the ideas, at least as a minimal threshold is that coded data in an old system ought to be consumable by the new system so that clinical decision support still works, so that at least I don't have to move backward. Now the hard part of that is how do you sort of set parameters around that, because things that are coded in one system for all sorts of proprietary reasons. And reasons that the vendor has decided to do because they are trying to improve their product and meet their customer's needs, may not be something that's coded in the next system, and for very legitimate reasons. So, those are some of the issues that we confronted as we talked about this – I'm sorry – go ahead Arien.

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

And just to be clear, we did definitely discuss that it was infeasible in the timeline that we were talking about to get to full EHR portability with the expectations, I'm using system "X" on day 1 and I'm using system "Y" on day 2 and everything works. We were talking about – we had a specific discussion about the core clinical record and confining our portability discussion solely to the notion of the core clinical record.

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

Right. So we did – we actually we went to the Policy Committee at least – we had at least two discussions at the Policy Committee and were asked to reconsider certain elements of it as we had moved it forward, because, and really that was sort of a reflection of the issue that Arien was just discussing there. So one of the things that we came to was that in the timeframe that we're talking about, it wasn't reasonable to expect that high-level goal that Arien had just articulated. So, the first thing that we did is sort of recognize that there's a lot of work that would need to occur to be able to reach the goals. And so the recommendation was to sort of create a multistep path to get us there. And so that's what we talked about, there are sort of some specific recommendations and then a recommendation for ONC to start a process to develop a little bit more understanding of this area.

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

So this is Josh, another clarifying question. When I read the phrase, provider data migration, I could interpret that two ways. The first way, which I think is correct, is you're talking about exporting data about patients, for use by providers who want to switch EHRs. The second way, which I assume is not what you mean is, exporting data about providers from the EHR system.

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

Right, its number one.

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

Okay, thank you.

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

So how is that – this is David.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Wait a minute, we only –

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

Well it would be both, I would think.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

We have only 3 minutes in this meeting and we need to open the lines for public comment. Should we, is there any way you can kind of really get through the rest of these very, very, very quickly with no questions – clarifying questions. And if we need to, we'll invite you back for another session or if you would prefer, we could do that as well.

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

Sure, no, I'd be happy to come back. So why don't we go to the next slide.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Okay.

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

And why don't we go to the next slide, just to get to the – and the next slide. Okay, so we had a lot of background here. Next slide, I'm just trying to get to the recommendations. So, here. So the recommendations were that the HIT Standards Committee by Stage 3 Meaningful Use, develop standards and specifications to address both of these use cases, where really the key things – the key gaps as we saw it were determining the necessary elements of a core clinical record. Because we went around and around on that, and it was felt that that would be an important first step on the path toward improving data portability. And then a suggestion that the Standards Committee explore the adoption of a core clinical record that's easily extractable and consumable by EHRs, so that was one part of the recommendation was to be able to at least get our arms around, is there a core set that we would say ought to be portable across all systems.

Next slide. And this was, this recommendation is directed at ONC to establish a long-term path to move the industry toward a practical patient portability and provider data migration solution that addresses the key policy concerns that were really identified in our Policy Committee discussions. Investigating the current state of the field, there was a lot of discussion at the Policy Committee about high degree of heterogeneity across systems, again, for very valid reasons that made it very hard to set a very discrete, clean, crisp requirement that would be achievable and meaningful in the timeframes that we're talking about. And create a needs assessment to lay the path for future standards. And then explore policy levers, because we did note also that that there are a variety of policy levers and if we're not going to do it in Stage 3, then certainly there may be Stage 4 and Stage 5, but you ought to really consider the other policy records – policy levers that could get you there as well. And we note some of those in the second bullet there. So, I think that's the last slide, Dixie.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Good. Thank you very much, Micky. I appreciate you – and this one, I actually think is – well, it might have more questions once we get to it, but you know, as we get to that third task, we may invite you back, David and I will discuss that later, okay.

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

Sure.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

But we really appreciate your presentation today and obviously there's loads of interest in these topics from our Power Team and it was really helpful, very helpful to hear your responses to the questions that were raised today.

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

Great.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

David, would you like to add any summary statement here before we move it up – open the lines for public comment?

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

No, I just express my thanks and thank you for putting up with all of our picky questions.

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

They were all great questions so, thank you.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Okay, Michelle?

Public Comments

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

Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. 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.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Sounds like they all dropped off there.

Caitlin Collins – Project Coordinator, Altarum Institute

We don't have any questions at this time.

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

We just want to give them substantial time to be able to call in.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Okay.

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

There is – sorry, go ahead Dixie.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Thanks to everybody for dialing in today and we will be announcing the next meeting shortly, at which time we will dive into addressing these three topics. I think the – well, I'm sure the first one, or I think the first one we are going to address is provider directories, and that will continue a discussion that we actually started I believe on April 17th, at our last meeting. And we'll refresh everybody about that discussion before – during the meeting. So, be on the lookout for the announcement of the next meeting. Okay, Debbie, anything you want to add?

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

On mute and no.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

And thanks to Debbie Bucci for her support. Okay, all of you have a good weekend.

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

Thanks.

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

Thank you. Thanks Micky.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck and Associates

Bye, bye.

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

Bye, bye.