



**HIT Policy Committee  
Interoperability & Health Information Exchange Workgroup  
Final Transcript  
October 21, 2014**

**Presentation**

**Operator**

All lines are now bridged.

**Michelle Consolazio, MPA – 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 Policy Committee's Interoperability and Health Information Exchange Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Micky Tripathi?

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

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

Hi, Micky. Chris Lehmann?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Good afternoon Michelle.

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

Hi, Chris. Arien Malec?

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

I'm here.

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

Hi Arien. Barclay Butler? Beth Morrow?

**Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership**

I'm here.

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

Hi, Beth. Brian Ahier?

**Brian Ahier – Director of Standards and Government Affairs – Medicity**

I'm here.

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

Hi, Brian. Carl Dvorak?

**Carl D. Dvorak – President – Epic Systems**

I'm here.

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

Hi, Carl. David McCallie?

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

Here.

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

Hi, David. David Whitlinger?

**David W. Whitlinger – Executive Director - New York eHealth Collaborative**

Cheers.

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

Hi, David. Deven McGraw? Hal Baker? Jitin Asnaani? John Blair?

**A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies**

Here.

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

Hi, John. Kitt Winter?

**A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies**

Hi.

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

I'm here.

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

Hi, Kitt. Landen Bain? Larry Garber?

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

Here.

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

Hi, Larry. Marc Probst? Margaret Donahue? Melissa Goldstein?

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Hi.

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

Hi, Melissa. Nancy Orvis? Ray Scott?

**Ray Scott, MSW – Arkansas HIT Coordinator – Arkansas Office of Health Information Technology**

Here.

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

Hi, Ray. Shelly Spiro?

**Shelly Spiro – Executive Director - Pharmacy Health Information Technology Collaborative**

I'm here, thank you.

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

Tony Gilman?

**Shelly Spiro – Executive Director - Pharmacy Health Information Technology Collaborative**

I'm here.

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

Hi, Shelly.

**Tony Gilman – Chief Executive Officer – Texas Health Services Authority**

Hi, Michelle, I'm here.

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

Hi, Tony. And Wes Rishel?

**Wes Rishel – Independent Consultant**

Here.

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

Hi, Wes. Are there any ONC staff members on the line? Okay, after that long roll call back to you Micky and Chris.

**R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health**

Hal Baker joining late.

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

Hi, Hal.

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

Great. Well, hi, everyone this is Micky and thanks so much for joining we have a great turnout today. So, really looking forward to the next chapter of the Interoperability Workgroup, I forget what we're calling this, the IO Workgroup or the IE Workgroup, we still have to work on that one I guess, but we are the Interoperability Workgroup so if you think you are on another call now is the time to drop off.

So, today we're going to talk about the JASON Task Force Report as a review to sort of level set everyone for the work that we have ahead which is to provide comments on the ONC Interoperability Roadmap and we'll talk a little bit about, you know, how we anticipate doing that over the next couple of calls, but that's, you know, sort of at a high-level we want to try to cover it today. Let me go to the next slide here.

And so we want to review the Task Force recommendations, the JASON Task Force recommendations. We did look at the Governance Sub-Workgroup recommendations last time on our last Interoperability Workgroup call so, you know, the task ahead now is on October 15<sup>th</sup> we did present both the Governance Sub-Workgroup and the JASON Task Force that David McCallie and I Co-Chaired, presented to the...could everyone mute their phones please unless you're going to say something, thanks.

And we did present on October 15<sup>th</sup> to the joint meeting of the Standards Committee and the Policy Committee, the Governance Sub-Workgroup presented there was no request for a recommendation from the Policy Committee or the Standards Committee so there was no vote or any approval of any of the materials that were presented there but you did...this Workgroup did look at that set of materials and we can, you know, certainly incorporate that in our thinking as we provide commentary on the interoperability roadmap.

The JASON Task Force followed the Governance Sub-Workgroup and we did present the presentation that we're going to go through here in a little bit of detail and we did have specific recommendations that we put before the Standards and Policy Committee for approval and with one amendment that we'll flag as we go through here, the Policy and the Standards Committee did unanimously approve the recommendations here. So, this sort of provides our basis then for, you know, the next set of meetings where we will be providing comments and input to ONC for the interoperability roadmap.

So, let me just pause here and allow Chris, my new Co-Chair, who I want to welcome first off and very much looking forward to working with Chris and see if, Chris, if you have any introductory remarks as well. Chris, might be having difficulty, maybe he is on mute.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

No, no, no sorry I had to take myself off mute I'm in a pretty noisy place. So, because of that I just wanted to say I'm looking forward to hearing again the JASON Task Force Report and I'm looking forward to working with you and I'm going to be relatively quiet for the rest of the call.

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

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I'm going to go and turn it over to you.

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

Thanks. And the JASON Task Force is just gripping so no matter how many times you've seen it it's just...I know everyone will agree. So, certainly for those who were in the Policy Committee and the Standards Committee meetings or who were on the Task Force I apologize that we're reviewing some, you know, some material that you're very familiar with at this point and certainly would understand if you dropped off, but we will be reviewing that because there are a number of members of the IO Workgroup who actually were not a part of the Task Force and I don't believe are on either the Standards or the Policy Committee so it's important for us to level set everyone's understanding of the Task Force and what was approved by the Policy and Standards Committee and then we can, you know, sort of talk about the next steps and what we want to do in the next set of meetings with respect to the interoperability roadmap. So, next slide please.

And so, you know, this is the membership of our group I think everyone is hopefully familiar with it, it's a big group but importantly it's got great cross section and a lot of representation from, you know, sort of full 360 degrees of stakeholders here. Next slide, please.

So, as I said, you know, the charge, you know, is to look at the Task Force, that's the immediate charge, we've obviously got a bigger charge for the Interoperability Workgroup itself which unfolds over time but most immediately we want to look at the JASON Task Force, Governance Subgroup and then we'll start to look at the interoperability roadmap. Next slide.

Our process and timeline is, where are we today, we're at the 21<sup>st</sup> so we're going to review the Task Force, get the...review the feedback from the Policy and Standards Committee. We have one meeting on the 29<sup>th</sup> that will, you know, sort of be our first opportunity to take what we have from all of our collective knowledge and experiences as well as from the JASON Task Force, as well as from the Governance Sub-Workgroup and whatever else we want to bring to the table to start to provide some feedback and input on the ONC interoperability roadmap.

And we just have that one meeting before we have to, you know, present something in the way of preliminary thoughts for the November 4<sup>th</sup> Policy Committee meeting, you know, but we don't have the final recommendations due until a month later, so, you know, so the way that these things have normally unfolded, you know, our ability to just even present a high-level framework for how we're going to think about that and any immediate red flag areas I think would, you know, would suffice for just the quick report out to the Policy Committee on November 4<sup>th</sup> and then we'll have a little bit more time with a few meetings to spend more time refining our thoughts.

And then there is, you know, something later on after the December 2<sup>nd</sup> meeting which we'll touch on here in the JASON Task Force Report which is there is a recommendation from the JASON Task Force and I think it's in the interoperability roadmap as well we're not the only ones, and the Governance Sub-Workgroup also did have a recommendation on this, which is to provide better...to have better measures of, you know, interoperability and what exactly does that mean. So, I think that the December 16<sup>th</sup> meeting there is sort of a placeholder there for us to perhaps engage in that question that is sort of tentative right now pending, you know, how the meetings and other things unfold. Next slide, please.

So, I'm going to dive into it, I know Dave McCallie is on the phone but he is probably in the airport, so David I'll just...I'll keep plowing through you feel free to jump in whenever you want.

So, let me go ahead here and I'm going to do it at a pretty high-level and a pretty brisk pace so people, you know, can stop me wherever you have questions, but, you know, I think for the most part, you know, our focus, you know, for this Workgroup is what were the recommendations and I think everyone has probably some, even if you haven't read the report, I suspect most of you have some background in, you know, what the JASON Report said but for our purposes it's actually not as important what the report said because, you know, we're now dealing with the recommendations that have been approved by the Policy and the Standards Committee that we now sort of take as inputs into, you know, the assessment that we provide on the interoperability roadmap. So, I'll focus less on the background and much more on the recommendations that we made. So, next slide.

So, you know, at a high-level the JASON Report, you know, was fairly critical of the current state of interoperability. This first slide just points out and you'll note this, you'll see this in the rest of the presentation that when we refer to JASON or the JASON Report we're referring to the original JASON Report which was authored by the JASON advisory panel which is a federal government advisory group.

Whenever you see a reference to JTF or the JASON Task Force that reflects the, you know, sort of the thoughts and comments of the JASON Task Force itself which was an ad hoc Task Force jointly created by the Standards and Policy Committee to review the JASON Report.

The only reason I wanted to make this clear is there is a lot of confusion in the press where the press was reporting things, attributing to David and I and to the JASON Task Force findings that actually were from the original JASON REPORT that weren't from the JASON Task Force. Next slide, please.

So, this was the charge of the Task Force itself. Why don't we go to the next slide, please.

This was the group, as I said, Dave McCallie and I Co-Chaired it and we had a, you know, great cross section of folks both providers, research community, federal government as well as vendors represented both from the Standards and the Policy Committee. Next slide, please.

We had...I think we met eight times and we had two listening sessions. I won't go over in detail what, you know, the findings from there, they're really reflected in our recommendations themselves. Next slide, please.

So, the summary, next slide. So, just to...one page synopsis of the JASON Report is that it's highly critical of the status and trajectory of healthcare interoperability in the US today. It points to the lack of an architecture supporting standardized APIs and they also, you know, sort of point the finger at EHR vendor technology and business practices as impediments to interoperability.

And they recommend based on those findings the creation of what they call a unifying software architecture to essentially migrate data from what they call legacy systems to this newly centralized orchestrated architecture to better serve three use cases that they focused on clinical, research and patient uses.

And they recommend that ONC define, you know, quoting their words "an overarching software architecture for the health data infrastructure within 12 months." And we just made a little note that the JASON Report was published in November 2013 so we have one month left to stick to that original timeline. Next slide, please.

The JASON Task Force, so now I'm just jumping to where do we agree and where do we disagree with the JASON Task Force and we actually, as a Task Force we had a very high degree of consensus in agreeing very strongly with the main conclusions and the main recommendations of the JASON Report.

As you'll see in the next slide we had some things that we disagreed with but, you know, overall the thrust of the JASON Report we actually agreed with. But, can you go back one slide, please. I just want to cover the points of agreement first.

So, the points of agreement that we had a high degree of consensus on as I said in agreement with were that the foundation of interoperability should ultimately be an orchestrated architecture based on public APIs. That current interoperability approaches are functionally limited and need to be supplemented and gradually replaced with more comprehensive API-based models.

And in particular what we were pointing to there is that current approaches that are document-based and are essentially, you know, sort of push of document-based kinds of...and the ability to request but not the ability necessarily to write at an API level are functional limitations that, you know, that would really sort of, you know, impede the ability to move to the next level of interoperability.

So, the idea here is that we need to move to the next level and there is obviously a transition period. So, you know, certainly in the near-term we would imagine the current approaches are supplemented and gradually replaced over time with more comprehensive API-based models.

And then finally, that Meaningful Use Stage 3 should be used as a pivot point to initiate this transition. We don't believe that, you know, Meaningful Use Stage 3 is everything and indeed it's, you know, sort of diminishing as a lever and an influence in the market, however, we do believe that there is some urgency to having Meaningful Use Stage 3 be at least one lever that's used because it's a very unique lever in the market that we think that we don't want to lose the opportunity to use. And we'll dive into that in a little great detail in a second. Next slide, please.

There were some things that we disagreed with the JASON Report that were, you know, mostly in the way of their findings that, you know, but again ultimately, you know, we can agree or disagree on their findings, as I said we strongly agreed with, you know, with the thrust, the main thrust of their conclusions, but we did have some disagreement with some of their findings. I'll just tick down these very quickly because I really want to move to the recommendations.

So, first off we don't think that, you know, in their findings that they accurately characterize the current state of interoperability, you know, in some ways that's neither here nor there, again, because we agreed with the thrust of what they were saying which is that we need to move forward, you know, to a new paradigm.

We don't agree that an evolution toward an API-based architecture should or even could require this idea of migration from current clinical and financial systems. You know there is a very large install base and, you know, it's our, you know, belief that, you know, innovation happens in multiple ways and in multiple platforms.

So, you can have innovation happening from new platforms but there is a lot of innovation happening from current platforms and the point is to move to functionally what we want to accomplish with this API-based architecture and focus less on what one might call a legacy system versus a current or, you know, current generation system.

The third point is we don't agree that the various interoperability is primarily a software engineering problem. The JASON Report does note that there are a number of other dimensions that are non-technical in nature that are impediments to moving forward with interoperability but what they note though is they specifically don't address those and, you know, that was part of their assumptions going in was that they weren't going to address those issues.

However, given that they expressed some urgency with moving to this new API-based architecture, you know, we believe you can't ignore those other factors and so we, you know, in our recommendations tried to address those other factors as well.

Fourth, we don't agree with, you know, what is essentially a very strong implicit assumption in the JASON Report that market mechanisms are ineffectual and indeed in some places there is a suggestion that they're harmful means of advancing interoperability and indeed we believe that market mechanisms are probably going to be the primary driver of enhanced interoperability and therefore that minimal if any federal regulatory intervention is desirable at the current stage of market development in the trajectory.

And then finally, we don't agree with the JASON Report's implicit assumption that strong top down control of a unifying software architecture is either feasible or desirable in today's healthcare market and we have specific recommendations related to what we call a coordinated architecture which tries to, you know, get at some of the same things that we believe is something that would be feasible in the market today unlike the suggestion that they made for something that's very strong top down which didn't strike the Workgroup as being something that would be feasible. Next slide, please.

So, before...well why don't I just jump into the detailed recommendations then I'll pause after each one and invite anyone to ask comments or certainly anyone else on the Task Force to please provide any color that you'd like to provide. So, next slide, please.

Our recommendations were...so we had six specific areas of recommendations, this is a high-level description of each and I'll dive down into each one. If I was going to, you know, sort of characterize them, you know, at a high-level I would put them into three buckets. The first is number one which is that the Meaningful Use Program should shift its focus to expanding interoperability and should essentially, you know, narrow the focus of interoperability to focus on interoperability, essentially raise the bar on interoperability and get rid of a lot of other requirements that tend to create a lot of complexity and vendor certification and provider attestation, and therefore slow down, you know, sort of progress on all fronts.

And, you know, it was the strong sense of the Workgroup that we can move forward aggressively in interoperability that's where the greatest need is and one thing that would be incredibly helpful to that is that if the Meaningful Use Program really focused on interoperability at this point and tried to, you know, strip away a lot of the other ancillary kinds of requirements that add a lot of complexity, a lot of development time as reflected in, you know, sort of the current low attestation rates that we're seeing with Meaningful Use Stage 2.

And part of that would be having Meaningful Use Stage 3 and the associated certification be the initiative, the initiator of adoption of public APIs. Again, just, you know, essentially getting a toehold in this concept of public APIs with the expectation being that with that toehold the market could then, you know, sort of determine the, you know, the trajectory and the, you know, scale of the use of public APIs but that Meaningful Use is an important lever to get that, you know, sort of industry wide compatible implementation of a public API instantiation. So, that's the first one is focus interoperability, focus on interoperability.

The second main point, and that's really covered by numbers two through five are the, you know, sort of the public API as the basic conduit of interoperability in the future. And again there is a transition period. There is, you know, that is not to say that it replaces current approaches overnight or that, you know, that these many approaches could live in parallel but that the public API as a basic conduit of interoperability should be added to the mix as soon as possible. So that's what two through five cover.

So, we have focus on interoperability, public API and then the last one is the role of government where the Task Force felt pretty strongly that a regulatory approach to this should really be the last resort and that there were many, many levers that the government could pull in its role as market participants, convener, provider of guidance, you know, a number of things that the federal government could do that could have a lot of influence in motivating the market toward taking greater responsibility and having the industry take greater responsibility for accomplishing interoperability that would be non-regulatory in nature and probably more influential over time.

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

Micky?

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

Yes?

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

It's David, just one comment on that, that we discussed in the group that may not be obvious is the definition of the word regulatory. In the sense that we're using it here it's sort of assertive regulatory constraints on the market as opposed to the regulatory power to, for example, define a certification standard and to create incentives. So, it's in some ways in Meaningful Use and the certification part that is regulatory but that's not the sense in which we meant it here.

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

Right, yeah, thank you for adding that Dave, yeah and David that's a great point. Because David and I actually had a back and forth on, you know, is HITECH regulatory or not regulatory and so, you know, you could look at it one way and says, well it's not regulatory because it is a voluntary program, no one is required to participate in it, you can decide not to as a provider and not take the incentive and then take your penalties down the road, you know, no one goes to jail for, you know, for not accomplishing Meaningful Use.

On the other hand, it's certainly for, particularly on the vendor side has the effect of being regulatory to the extent that it creates a market standard that everyone has to follow and it's certainly very difficult for a vendor to survive in the market without getting certified to the, you know, the success of ONC certification.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

So, let us clarify this just for me. So, if I hear about a federal rule, proposed rulemaking, in this case the JASON Task Force was not opposed to that, not opposed to regulation related to HITECH but let's say what you were opposed to let's say is new congressional mandates that might be imposed. Is that correct?

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

I guess I would just refine that a little bit to say that I think as a Task Force we saw the exercising of existing authorities under HITECH as not necessarily being regulatory in nature and that what we're talking about when we say non-regulatory is having any kind of new authority that would either be regulatory or statutory whatever the source is that would essentially, you know, sort of have greater authority over health information exchange and interoperability than could happen today under existing authorities from HITECH.

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

And this is Arien, I think

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Or other...

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

I think...this is Arien, I think it's worthwhile...

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

Yes.

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

Restating that Jodi was pretty clear that the one sentence in the HITECH Act that stated something like ONC shall have the authority to govern the Nationwide Health Information Network. ONC is interpreting that as providing fairly broad legislatively granted regulatory oversight. So, ONC does have more tools than just Meaningful Use in terms of regulating...ONC believes it has more tools than just Meaningful Use than just regulating if it needs to.

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

Right.

**Brian Ahier – Director of Standards and Government Affairs – Medicity**

And this is Brian I'd also, you know, I think there has been a lot of discussion about the importance of the decoupling of certification from Meaningful Use. So, while the focus on interoperability in point one in the recommendations about Meaningful Use Stage 3 I think is really important and valuable to focus that stage of Meaningful Use on interoperability. I think there are opportunities to leverage the certification program for other purposes outside of Meaningful Use that can be just as valuable in this context.

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

This is Shelly Spiro I'd like to comment on that one point. That's especially important to those who are actually ineligible for Meaningful Use, you know, such as pharmacists and long-term post-acute care, behavioral health that have really struggled with not being part of the Meaningful Use Program.

So, moving forward in this direction is really important to those who really have not been part of the Meaningful Use Program.

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

Yes, great point.

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

And this is David again, the reason I raised this issue for this discussion is that a number of people who have reacted to the JASON Task Report, JASON Task Force's presentation have kind of oversimplified and said that it said there is no role for government in improving interoperability and I don't think we're calling for that at all we're just calling for a very focused approach centered around certification and incentives rather than a more aggressive regulatory approach. So, I think it's a point of clarification in the way that people have interpreted our statements so that's the reason for bringing it up.

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

Yes.

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

This is Nancy Orvis in DoD. I wanted to reiterate that I think that point is extremely important because there are lots of functions not only just a lot of roles like the clinical roles that were just mentioned, pharmacy, where information exchange or the ability that that module of an EHR system needs to be able to send information or other modules need to have access to it.

I think the only thing that I have a question on is I'm not sure where certification is happening these days given...or are we basically saying go forward and continue to work on certification, because I thought that they were running out of...I thought ONC had run out of money for more certification programs. Does somebody have a...

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

Yes, well we didn't get into whether they would be able to sustain it but we were assuming that ONC would or under ONC authority there would continue to be some type of federally sponsored certification however that happens.

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

Maybe...

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

I mean, it could turn into market, you know, market-based, you know, certification that has, you know, validation or credibility in the market, I mean, that could certainly substitute for it over time.

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

Sure.

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

But we're assuming some type of industry-wide certification that people would respect that would be market meaningful in some way.

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

Does it make sense of trying to put a little bit more emphasis that this is a key assumption that these recommendations work with a key assumption, that there is that going to continue on?

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

Well, yeah, we're not going to modify these recommendations but that's certainly a point that we can make when we provide input to the ONC interoperability roadmap.

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

And I'm speaking partly with my Ex-Officio hat to say it behooves me as a care provider that we'll not be going out of business in 20 years or 30 or 40, 50 years as a federal provider of healthcare that I would know that there was some continuing ongoing way of assuring that products on the market were certified.

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

Right.

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

Yeah and that is whether I was a public provider or a private practice provider it would make sense to see that this happened, okay.

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

Yes.

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

Okay.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Micky?

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

Micky, one more input from David which is just to say that this recommendation probably should be coupled with number six where we call for measurement standards for actual interoperability and interchange and then transparency around what actually is happening in the market so that you have a forcing function that is based on the notion of, you know, unified measures and transparency and I think you have to couple that with certification recommendations to kind of get the full picture of the role that is outside of industry by itself.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Hey, it's Melissa...

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

This is Shelly Spiro, I'd like to make another suggestion/comment I'm not quite sure where it fits, but, you know, there are other driving factors besides just the governing regulatory process.

If ONC, just as an example, were to link certification to some type of accreditation related to payment such as, you know, accreditation through Joint Commission or other aspects, so in order to meet your accreditation process, whether that's through an ACO or any other type of organization, that certification was linked to that accreditation. Has that been discussed?

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

Yes, so the Task Force, you'll see in the recommendations of the Task Force that's one of the recommendations is that we shouldn't just be focusing on Meaningful Use Stage 3 that the government has a wide variety of incentive and accreditation and regulatory type of mechanisms that are already in place that all should be aligned, you know, toward the public API.

**Brian Ahier – Director of Standards and Government Affairs – Medicity**

And this is Brian, just to address I think some of the...put some context around the certification program which I think is going to be extended certainly beyond Meaningful Use, it's already being leveraged by CMS for instance the 2015 physician fee schedule includes the requirement for use of certified EHR technology to bill for CCM and ToC billing codes to CMS.

They have also, in the plan, the FDASIA Report, currently as they're trying to determine the development of the Health IT Safety Center specifically mentions leveraging the certification program that is overseen by the ONC.

So, I think that it's already happening and we're likely to continue to see more movement towards certification being leveraged for other purposes and this decoupling of certification for Meaningful Use I think again is a really important concept for us to consider not only in these recommendations but in particular as we start talking about the interoperability roadmap.

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

Yes, great points.

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

Micky it's Melissa Goldstein,

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

Yes?

**Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University**

I just wanted to say something about this regulatory, non-regulatory language division. ONC is a regulator, right, that's what they do, they regulate. They have...as Arien said, they have lots and lots, and lots, and lots of different tools that they can use short of formal notice and comment regulation, which incidentally Meaningful Use Stage 3 is formal regulation.

So, generally in the legal field we refer to those other types of ways of doing things as sub-regulatory and that can include guidance as well which is also less formal but it is, you know, a formal tool of a regulator.

So, I think that the language that you were using when describing it as, you know, firm, decisive moves regulation issuing regulation more statutory legislation that sort of thing, avoiding that, that's probably better than saying HITECH is not regulation and HITECH is not regulatory because it absolutely is. Does that help or does that just muddle things further?

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

No it doesn't muddle things, I mean, I think it's...I guess the main point is that we think that there are a number of what you would just characterize as sub-regulatory levers that we think that ONC could use that would be very influential and we were drawing a line, you know, albeit a non-legal line that essentially was saying that, you know, regulatory suggests that, you know, someone goes to jail if they don't do this thing and that's why we were putting HITECH on the other side of that by saying, well, no one goes to jail for not, you know, for not meeting Meaningful Use, you know, you just take a penalty.

You know, but I think that's a fair point and I think it will be useful for us in our inputs to the interoperability roadmap to be very clear in the use of our language. I completely agree with that.

So, why don't we move forward and all of these are great comments and we're actually now on the next set of slides, I'm just diving down into each one of those, so we'll have the opportunity to dig down further into each one of these areas. So, next slide, please.

So, some of it...some of these things were already covered in some of our conversations so I'll go through rather quickly, but again, please stop me at any time. So, the recommendations that we had, there were three types of...there were three specific recommendations in this category number one which is focus Meaningful Use on interoperability.

The first, as I said, is to limit the breadth of Meaningful Use to shift the focus to interoperability, you know, sort of we based that on, you know, looking at the Meaningful Use Stage 2 experience that shows that, you know, overly broad and complex requirements tend to slow progress on all fronts and we believe that focusing on interoperability will both send a strong signal to the market about, you know, the preeminent importance of interoperability, you know, as we go forward and it will allow providers and vendors to focus resources on interoperability related activities as opposed to, you know, a very broad array of Meaningful Use requirements.

The second recommendation that we had is, you know, sort of getting a little bit more specific that we believe that there are three complimentary HITECH levers that should be exercised. First is related to certification. So, add certification of highly constrained public API to CEHRT standards. So, the first is, you know, get a public API, an initial highly constrained, you know, public API specification into CEHRT. So that's the first thing. So, get it into the technology.

And then the next two were about, you know, sort of the motivational aspects one on the vendor side, one on the provider side which is, you know, you can enable that, you can put the technology into place but if no one allows anyone to use the, you know, the API or the public API then you're not going to accomplish what you want to accomplish.

So, the first one is about getting the technology in place and then next two are about first encouraging and getting the vendors to not unreasonably prevent access to the public API and the reason we have encourage and motivate there is that right now there aren't, you know, at least in our understanding, aren't any clear regulatory means or, you know, any kind of, you know, existing levers that ONC or CMS would have to, you know, to tell vendors that they have to do this.

You know incentives don't go to vendors. Certification is just about the certification and the technology but there is nothing about the behavior of vendors so that's what this is getting at. So, that's why you see the language there of encourage and motivate vendors to not unreasonably block access to public APIs. And, you know, based on appropriate business and legal convention. So, we'll talk about that a little bit later.

And then the second is on providers and here you do have a lever which is the incentive programs and Meaningful Use Stage 3 as well as others, you know, as Brian has just noted there are other incentive programs as well.

So, the idea here is structure the incentive requirement programs so that providers can't unreasonably block or don't unreasonably block access to public APIs, again, based on appropriate business and legal conventions. So, that's the second recommendation. And then next slide, please.

And then the third is, how do we move forward. So, the immediate recommendation is to take the, you know, the recommendations from the JASON Task Force and we believe that there is some urgency here because of, you know, sort of the timelines related to HITECH in particular. Again, we think that there are many, many other levers but HITECH is somewhat unique and has a very specific timeline so we believe that there is some urgency there that we want to act on.

So, to motivate industry wide API-based capabilities and the act on that urgency the recommendations were one, that ONC should immediately engage the FACAs to further flesh out the JASON Task Force recommendations on public API-based architectures.

So, the idea here is, you know, we were a Task Force, we met eight times, you know, we think we did a, you know, pretty good job but, you know, it takes...there is further work to do and so taking it down, you know, one more level in terms of level of detail having a little bit more focus in a public/private, you know, sort of collaboration and the FACAs are immediately available to provide that kind of expertise and input.

So, the first recommendation is to leverage the FACAs to further flesh this out. The FACAs, however, are not operational, they are advisory groups so they can't really do anything operational and so that leads to the second bullet which is that ONC should immediately contract with an SDO or other recognized operationally active industry consortium to accelerate focused development of an initial API, an initial public API and core data services and profile definitions, we'll talk about what those are in a second, for inclusion in Meaningful Use Stage 3 and associated certification.

So, there is an accelerated development process that would have to happen, a very focused one, and that's not a FACA activity that's something that really needs to be, you know, sort of very crystalline and cleanly identified with a clear set of, you know, milestones and deliverables and timelines. So, that's the recommendation there is that ONC should, you know, instigate the contracting for that.

And then third, and this is highlighted in red because this is...this was modified in the Policy and the Standards Committee meeting on the 15<sup>th</sup>, it was the only change that was recommended before we approved, and this was that CMS and ONC should consider mechanisms to accommodate an accelerated development process for a feasible initial public API specification. The concern there was about timelines.

If you look at Meaningful Use Stage 3 timelines in particular, you know, how do we line up this accelerated development where, you know, the Meaningful Use Stage 3 timelines might, you know, might be a little bit too near-term to be able to accomplish that.

So, this is just saying that CMS and ONC should consider mechanisms broadly to figure out how to accommodate this accelerated development process of a public API into the incentive programs including Meaningful Use.

**Carl D. Dvorak – President – Epic Systems**

Hey, Micky?

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

Yes?

**Carl D. Dvorak – President – Epic Systems**

This is Carl.

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

Hi, Carl.

**Carl D. Dvorak – President – Epic Systems**

One thing that occurs to me and having experienced Meaningful Use through the current part of the program is that it lacks a focus on quality and although it's easy for government to subcontract and to allocate funds and such I'm worried here that the urgency is sort of overpowering quality.

And I think for something of this...that is as important as this could be for our future we should have a specific call out to not sacrifice the quality and the thoughtfulness of it under some sense of urgency so we can slam it into Stage 3 of Meaningful Use.

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

Yes, yes, I think that's a great point and maybe that's something that we can put in the roadmap recommendations as, you know, sort of some consideration for how we would do that but we were certainly concerned and very sensitive to, you know, sort of the experience, and I'm not pointing to this as an experience as an issue of quality, but the experience of putting out a standard that didn't originate for the market, right, namely Direct and all of the issues related there.

And you can imagine that if you had something that is too accelerated and is low quality by some measure that you would face a lot of, you know, similar and indeed other, you know, kinds of issues on top of that.

**Carl D. Dvorak – President – Epic Systems**

Well, and I think that...

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

...

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

So, may I ask in that context, Carl, what you define as quality exchange. Can you be a little bit more specific there?

**Carl D. Dvorak – President – Epic Systems**

Well, it's hard to be specific because most of these recommendations are exceedingly generic and, you know, any computer system, be it Cerner, Epic, Allscripts, whomever we all have many hundreds of thousands of APIs and we could probably all push a button and put a RESTful wrapper or a SOAP-based wrapper and publish it to the Internet.

So, I don't think the mechanism of making a service call a published API is at all tricky or difficult. Where it gets difficult is, understanding what are logical groupings of things, what things go together, how would one do an order.

Think about shopping for groceries, right, you could make a thousand trips to the store and get one item each time or you can go to the store and fill up your basket. So, when it comes to things like APIs they have dramatic impact on performance, scalability, system reliability. You will have to have some sort of transactional recognition especially if you've got read and write things going on that maybe dependent on other work processes.

So, these things become really important for the security, privacy, reliability of healthcare and I wouldn't want to have to implement something just because someone who doesn't actually do this for a living thinks it might be a good idea, because these things are complex and tricky to implement.

And the power of the regulatory or possibly sub-regulatory or non-regulatory world...if I have to do it by rule I'd rather make sure that we had a good quality pathway here and not just slamming something in because it was the last kick of the can on the HITECH money.

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

Yes.

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

This is...

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

Yes, I think it's a fair point, just one point I want to make and then we'll go through the queue here. I think, you know, one of the things...I think it's a great point Carl and one of the things that we, you know, tried to do is try to strike this balance by saying, you know, how do we narrowly define it and that's a part of the further work here.

I mean, we have some thoughts of how to, you know, how to define it and at least narrow the scope of it to high value use cases constrained in a way that could be feasible in the timelines that we're talking about, because, you know, I agree you can't just say "oh, public API" and that just opens up everything, you know, and there is a lot of ambiguity there and a lot of different ways to do things.

And so the idea here is how do we sort of strike that balance between narrowing it enough to something that's actually meaningful but that is also feasible in these timelines and I think our sense of feasibility was, you know, was related to your comment on quality, that it's got to be, you know, sort of quality enough that it's worth and that its implementable, and then something you can achieve.

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

This is Larry...

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

So, someone had a comment, go ahead Larry and then there was someone else in the queue I'm not sure who.

**Wes Rishel – Independent Consultant**

Wes.

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

Okay.

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

So, I agree with a lot...I agree with what Carl is saying and wonder if we ought to at least say, you know, technical and clinical quality, because, you know, there is certainly a lot of excitement about FHIR and there is a lot of emphasis on the technical functionality of FHIR, but there is certainly the, you know, lagging behind in terms of the clinical quality and modeling to FHIR.

And, you know, I want to make sure that we don't lose, you know, that as we bring out an API, you know, it has to be medically logical not just technologically possible.

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

Yes, Micky, this is Shelly Spiro, wanted to comment on what Carl said and maybe also adding the word "safety" into the mix might be a little bit more clinically specific to help with that. And that could also tie into some of the safety initiatives that ONC is working on in relationship to this. Because leading to what...if we get...if information is transmitted in a quality way that does lead to safe exchange of information not just...

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

Right.

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

From a security stand-point and privacy but also from other aspects of just wrong data coming across.

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

Right, right.

**Wes Rishel – Independent Consultant**

Wes.

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

Well, I think that's the idea of focusing on some...a very specific initial set of core services and core profiles to limit the set to things that you think that you can define with high quality in the timeline that we're talking about and that may be a very, very narrow set because we're just at the beginning of the beginning here.

**Wes Rishel – Independent Consultant**

Micky?

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

Sorry, Wes, go ahead?

**Wes Rishel – Independent Consultant**

Thanks, it would be hard to disagree with everything that's been said starting with Carl going forward and it's with trepidation that I pick on a specific thing he said which was the shopping cart analogy. Because to a certain extent what we've been trying to do is tell everyone to use a shopping cart with a...a full shopping cart with standard contents and that hasn't worked.

And the whole notion of an API is to provide a capability, a general capability to be fairly focused in what information you're dealing with and we don't want to lose the learnings that we've had in trying to go back to the whole shopping cart.

I specifically think that we need to deal with this issue of safety, quality and whatever, clinical and technical quality with an approach that's based on making the general capability available of the API and overcoming the experience we've had on how providers and vendors, I don't think, meaning intentionally, but, end up putting obstacles in the road. And then seeing how that is used before creating very specific requirements that represent a broad mandate.

And I think if we view it as doing the necessary standard and operational things to make the facility available as opposed to specifically making clinical decision support work better or specifically making patient oriented displays of data work better or something like that then we have a good chance to mimic the way things work in an unregulated industry in the sense of if the standard is there good ideas will raise to the top and difficulties will be overcome and teach us how to overcome those more in the standard rather than in an ad hoc way. Thanks.

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

Okay, was there someone else in the queue?

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

Yes, this is Kitt Winter, if...

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

Yes?

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

I had just a few questions on the public API in the way it's being recommended. Will this highly constrained public API that you're describing handle multiple architecture patterns such as push, query response, public subscribe?

And in the recommendation that you were just discussing I think that there is a large timing issue here and how do you get these public APIs defined, approved, adopted, tested, certified all of these activities take time and the other major challenge that I see is rushing that public API out without trial implementation or pilots to gain feedback and fix whatever is needed before the national rollout.

Because I think there are a number of questions behind this recommendation. I mean, will it be constrained to particular workflow patterns and use cases? Will security be part of it? And how do we prevent these proposed APIs from becoming functionally limited as we mentioned about our current interoperability approaches that we've been discussing?

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

Yeah, I think...

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

Micky?

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

Yeah, go ahead, David.

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

Well, I'll just take a quick shot at that. I think what's different about the APIs that we are considering here, and I'll use FHIR as the closest exemplar that we discussed because we think it is actually pretty close to what we're talking about, is these are general purpose tools to manipulate well-defined clinical resources like patient's encounters, problems, medications, allergies and they are in that way different from many of the APIs that we are currently implementing and using which are focused on specific sort of narrow use cases like sharing of documents or moving of a lab result from one place to another.

So, they are more open ended and powerful, and if you want to be technical orthogonal APIs leveraging for capabilities that help the Internet get to a...and well-defined chunks of data, the resources, that get moved around. So, they could be put to many more use cases than the current batch of APIs that we are, you know, all using today.

So, we think this is a forward looking thing, it opens up the opportunity for few ways to interoperate that go beyond the fairly prescriptive approaches that we have today. It won't replace them immediately but in the long run supplement them with more powerful choices.

That said, you know, it requires us to be careful about it because these are low level powerful services exposing data this way. So, the good news is the vendors have already done it in their own proprietary way but what we're really calling for here is unification around the standards-based approach.

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

Thanks, David.

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

And I'll stop there.

**Carl D. Dvorak – President – Epic Systems**

And I do think that we should do this in close cooperation with folks like David and Arien, and ourselves who have actually done these in production. We run some systems with 10, 20, 30,000 users on them and performance and efficiency, and reliability become critically important.

So, I do think, you know, again if we're talking about a couple of specific FHIR things it would nice to go ahead and name them because the commentary here is so very generic you could really define this to be anything you want it to be once you have the regulatory pen.

But I do think here we should closely involve the developers who actually understand how these work rather than folks who don't actually develop.

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

Right, yeah, no absolutely and again, you know, we do talk a little bit, you know, about narrowing that focus to the extent that, you know, at the JASON Task Force level we could and, you know, I will point out that the JASON Task Force had a lot of people on them who do this for a living, all the people you just named. So, it's not as if this was, you know, written by people who don't have experience and don't do this day-to-day and do it for a living. Next slide, please.

So, the next set of recommendations are related to, you know, sort of the ecosystem that we proposed which is about the public API itself as well as, you know, some ecosystem considerations around that and part of this reflects, you know, the experience from Direct and, you know, knowing that and seeing that out in the market, you know, just implementing a technology without an ecosystem there presents a set of challenges and means that, you know, that market ecosystem has to develop over time and there are some important facilitating roles that those market ecosystems play to enable whatever type of transaction you're talking about.

And so, you know, as we thought about this we, you know, sort of thought about what is that ecosystem that one could imagine, you know, sort of surrounding the public API to help facilitate public API-based transactions.

But just to be clear the public API concept is at the clinical or financial system itself. The idea here isn't that you are, you know, required to have any of these other elements in order to be able to use the public API.

The idea here is that these are, you know, sort of facilitating networks in the way that those networks develop today to, you know, to enable a group of participants to have the appropriate business, legal and specific implementations that can enable them to do a set of things that they themselves decide or are high value and that they like to automate. So, that's really sort of building on that concept here.

So, I'll describe, you know, sort of at a high-level the various concepts here and David if you're in a position to describe some of these as we go through, you know, feel free otherwise I can start and you can feel free to weigh in, you know, however you feel comfortable doing that.

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

Do you want me to just do this point while I've got a chance, because I'm going to have limited...

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

Okay, yeah, no, if you have a chance now that would be great.

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

Yeah, just take a shot at it. So, we took...in the Task Force we kept stumbling on the fact that we didn't really have a shared set of terms so rather than try to redefine existing terms we crafted some new phrases and new terms to just give us a focus point to talk to. We didn't necessarily get these correct but you'll see them hopefully used consistently throughout our report.

And first here is the notion of a coordinated architecture which you will recall we were responding to the JASON Report call for a national architecture and we're sort of saying let's have a loosely coupled architecture that leverages much of the Internet style approach to coordination as possible which is to say agreement on certain low level protocols and then letting markets define what to do with those protocols.

We attacked the governance problem implicitly here by defining something we call the data sharing network which would be better called a data sharing arrangement and DSA is probably better than DSN but it was too late to change once we had that suggestion.

A data sharing arrangement essentially is a group of people who get together and agree to use the public API in a way that meets business, legal and trust framework constraints and our assumption is that there will be more than one of those that needs to exist given the power of the public API.

So, public APIs could be put through very highly focused uses like say pluggable Apps, it could be something very generic like a feed to population health or it could be simple HIE style provider to provider data sharing and those might not all have to fit within the same data sharing agreement or data sharing arrangement because that would make the problem almost insurmountably difficult to govern.

So, the ecosystem would include multiple data sharing arrangements. The data sharing arrangements would be focused on the use of the public API and I think we've covered what that means, basically two notions that has a standard underneath it and it comes with some obligation around access and use of the API.

And then the API itself would leverage what we call core data services and Carl to your point about, you know, getting out of control with really aggressive and complex transactions in our appendix to the written document, they're not in the slides here, we kind of scoped this notion of core data services down to sort of fundamental data access primitives coupled with the minimum necessary authentication protocols necessary to do something useful in the real world something like OAuth 2 where you have to profile exactly how you use it.

And the notion was we would start with something simple and the first batch would be things that everyone can agree on as no brainers and then over time based on market experience, as Wes suggests, we could expand the definition of what's included in the core.

The notion of the core does not preclude anyone from going beyond the core. So, you could be participating with the public API and do much more than core data services and that would be fine and we expect actually that would happen, but you'd still be doing at least the core. So, it's kind of a floor not a ceiling and I'll stop at that. And Micky if you want add anything?

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

No, no I thought that was great. Let me pause and see if people have questions. We're going to dive down to each of these concepts into a little greater detail but want to make sure everyone sort of understands the basic terms.

**David W. Whitlinger – Executive Director - New York eHealth Collaborative**

I'm curious about a high-level set of discussions versus...of industry-based ecosystem compliance to the ecosystem, you know, roles and certification and so forth. Do you want to save that until the whole package is out and have that as a high-level discussion later or is now a good place to jump in?

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

We can talk...why don't we hold on that and I think it will come back in point six but if it doesn't we can, you know, sort of jump in wherever.

**David W. Whitlinger – Executive Director - New York eHealth Collaborative**

Okay and I guess just in broad brushstrokes on this slide I recognized the different technology things that are discussed as industry-based ecosystem I'd be curious what the other aspects of ecosystem might fit in here?

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

Yes, okay. And it might come up really as we go through it layer by layer.

**David W. Whitlinger – Executive Director - New York eHealth Collaborative**

Yeah.

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

So, why don't we go to the next slide. So, this describes...now we're just taking it layer by layer now, right, so just moving our way down here. So, the idea here, and this is responding to a specific JASON point as much as we could surmise, that, you know, rather than thinking of this as a single top down architecture that we think it is, you know, sort of much more prudent and much more feasible and realistic to think about there being a loosely coupled architecture that, you know, we've put the name of coordinated architecture on.

The idea was, as David said, loosely coupled based on scalable Internet principles to really accommodate some implementation heterogeneity that already exists in the market this wasn't about, you know, saying that we expect there to exist heterogeneity in the market there already is that heterogeneity in the market with existing networks that, you know, are plausibly data sharing networks or would be data sharing networks upon implementation of the public API using this, you know, sort of taxonomy here.

So, these are, you know, already things that are on the ground and are growing. So, the idea here is that this implementation heterogeneity is something that you have to treat as something that is already there and not pretend that it's not there. So, and that's the third point is leveraging and building upon the existing networks while encouraging new networks.

And then fourth, we don't envision necessarily that the coordinated architecture is necessarily an entity or an actual implementation that rather it could be standards and principles based on Internet principles and building blocks that with a critical mass of data sharing networks could, you know, sort of become something that evolves from the market up which is, you know, sort of how it's happened in other industries, but it could...that could actually, you know, then congeal into an entity or some kind of, you know, private-based collaboration sort of entity or consortium if that's what's seen as the market need.

But the idea here isn't to presume that is what would be needed at the outset but to, you know, see what happens as this starts to unfold in the market. And perhaps David maybe this is a little bit of what you're getting at, David Whitlinger.

**David W. Whitlinger – Executive Director - New York eHealth Collaborative**

Yeah, sorry, yeah, so if there is going to be this standardization how is that overseen. I love the idea of an industry ecosystem role here as you probably have heard me voice in other ways but I think there are other elements that are necessary and to ensure that it is a success other than just the technology.

So, it seems like at some point, I've gone through of course the rest of the deck I'm sure as many others have, I didn't see that called out, if it is there and if it is in there than it maybe needs to be highlighted in some more significant ways.

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

Okay, yeah, I mean, we didn't have, you know, specific recommendations related to what kinds of policies necessarily, what, you know, those legal arrangements would look like, what the policy arrangements would look like. So, if that's what you're getting at, you know, we didn't, you know, sort of dive down into that.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Yeah, well let me ask if, you know, I guess you could look at it as, you know, from other examples and, you know, the tech sector, the financial sector many have been brought up in these kinds of forums those alliances, industry alliances, industry forums is that what was thought of in the phrase of an industry-based ecosystem, you know, whether it be the ATM example and the alliance that oversees that set of interoperability technologies or WiFi alliance or what have you. Is that what was conceived of here?

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

Well, I think the idea...I think we were sort of thinking of this as ecosystems plural where you could think of the ecosystems as essentially being the data sharing networks and the coordinated architecture based on a set of principles and standards if that, you know, if in the, you know, sort of the trajectory of that this ends up with an industry consortium that perhaps with the government as a participant or the government as a convener of that, if the, you know, sort of the collective action problem is enabled to be overcome by the market itself, if that's what it results in well then the idea would be, well, you know, fair enough than that's what's needed or that's what's seen as valuable. But, you know, we weren't going in assuming that you would need that kind of specific entity or specific implementation.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

How does the coordinated architecture get coordinated?

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

...

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

Sorry, go ahead, Wes if you're going to respond at this point.

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

This is David I was just going to say something, but go ahead and Micky why don't you address that, David's question.

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

Okay, I think Wes had a comment and then why don't you go David. Wes, go ahead.

**Wes Rishel – Independent Consultant**

That was not me.

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

Oh, it wasn't you, okay. David why don't you go ahead?

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Yeah, so...

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

Yeah, I was...

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Oh, sorry, which David?

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

Oh, sorry, no David McCallie I think he was going to respond to your point David Whitlinger.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Gotcha.

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

Yeah, I was going to say that, you know, the quotes or analogy I think might be the notion that the coordination occurs at the level of something like the Internet Engineering Task Force on really high level issues that affect the breadth of the Internet but that the data sharing arrangements, data sharing agreements occur many, many, potentially dozens or hundreds of them at the level of specific business agreements to use the public API.

So there are some things of necessity will bubble up to the top level but hopefully most of the hard decisions can be made within a data sharing arrangement because they are the ones who have a specific business case and specific legal constraints to go operate within. What they have in common is that they all take advantage of the availability of the public API much the way the web takes advantage of HTTP and HTML, and BNF, and associated capabilities that everybody can use even if they compete in other spaces.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Right, okay, I get that. So, then where is the coordinated architecture and what body owns the public API and ensures it's development, it's cleanliness and conformance to it?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

I think maybe we should, you know, think about referring back to what the Governance Subgroup did, you know, the recommendation to come up with a proper private partnership to address some of those issues was something that was put on the table.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Okay.

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

Yeah, and I think some of that comes from...

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

That's fine if we're going to address that as, you know, part of this Workgroup. I was trying to...perhaps maybe I was exploring the word and how broad the word "ecosystem" was in this context.

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

Yeah, some of this gets addressed a little bit in the next couple of slides so we should probably move forward on those.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Yeah.

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

And some of it is, you know, left somewhat undefined that's the point of picking it up with this Workgroup.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Yes.

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

Right.

**David W. Whitlinger – Executive Director – New York eHealth Collaborative**

Okay fair enough.

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

So, why don't we go to the next slide then? So the next slide is, you know, focused now we're going down one layer, right, to the data sharing networks where the idea is that the nationwide exchange network should be based on the coordinated architecture that loosely coupled this notion of a data sharing network whereas David said, you know, really as we started to think through it, you know, we felt better with the idea of data sharing arrangements as a better word but, you know, we had network so that's the name that we kept.

But the idea is that these are data sharing arrangements that really aren't about enabling the public API per se but they're about providing the facilitating policy and infrastructure to support use of the public API.

So we see that there is sort of an internal function as well as and external function. The internal is within the DSN, you know, you could imagine the facilitating API base exchange among entities and this, you know, would have a technical component which is things like what technologies are used to identify patients or authenticate users across entities and then a policy component, what data or documents are assessable through a public API, what are the allowed purposes for data or documents accessed through a public API. Those are the kinds of things that happen within networks today whether you looked at what CommonWell is developing, what Care Everywhere does, what eClinicalWorks on its own network does, what, you know, what Hixny does, what the Mass HiWay does, you know, all of those are about that sort of combination of facilitating technical and policy components that enable those participants who voluntarily join those to conduct the types of transactions that they want to automate.

And then across DSNs the idea would be to implement services that would bridge across the different DSNs when this is deemed necessary. So, there are, you know, similarly there are cross network tactical components like what standards and protocols are used for different DSN patient matching or authentication and then policy components, how are out of network entities authorized and, you know, what data or documents are assessable which gets to some of, you know, what Carl was putting his finger on before.

The idea is that, you know, as I said before the clinical and financial systems that expose the public API don't, you know, they don't need a DSN to be able to facilitate that exchange it's just that in the absence of a DSN they would be, you know, essentially doing it one off on their own every single time. And so, you know, that's kind of the facilitating role that, you know, DSNs would play.

So, we could envision that the DSNs of the...the potential candidate DSNs are the networks that exist today and new networks that, you know, could define, that could get defined or be defined around different types of affinity. You could imagine, you know, research oriented ones or federal government oriented ones, or organizations who decide that they don't need a DSN they're big enough, DoD or anyone else besides, you know, we're big enough we're just going to, you know, handle all of this and all the policy and the, you know, sort of the technical infrastructure pieces on our own or facilitating Healthway, you know, if you are a participant in that kind of DSN and they perform those types of functions.

So, it's a very fluid and dynamic, you know, kind of market because that's the nature of networks and that's the nature of the Internet but there are multiple ways that this could happen and it ought to be flexible to those multiple ways. Unless there are any questions/comments I'm going to move to the next slide. All right, next slide, please.

So, the public API as a basic conduit of interoperability. This was...we spent a fair amount of time actually defining the public API and if nothing else this was, you know, probably one great contribution we felt like we made to the conversation because in the JASON Report, you know, the terms...there are a lot of terms that are thrown around that, you know, they, the JASON authors probably had a very, you know, specific definition of some of these things in mind but because we didn't have the opportunity to go and talk to them because the JASON process doesn't allow that, we, you know, sort of had to come up with crisp definitions that we thought were aligned with the concept that they were putting forward.

And in particular we wanted to define the notion of public API to distinguish it from, you know, terms that people were, you know, sort of conflating it with, you know, what might...how might that be different from an open API or people were even, you know, sort of conflating open source with the idea of an open API or a public API. So we wanted to have a crisp operational definition of, you know, what it means.

So, the public API should enable data and document level access to clinical and financial systems in accordance with what we call Internet style interoperability design principles. And it has two components really, you know, one is about the API part so it's the implementation of certain technical standards and I should note that there is a technical appendix that dives down into a lot more detail than is covered here in the slides.

If you look at the written report, which is available on the ONC website and I'm happy to, you know, forward it to everyone if you don't have it already, there is technical appendix that provides much more detail than I'm going to cover here.

But it has the implementation of certain technical standards and then in the corresponding agreement to meet certain obligations, governing, public "access" to the API. So the idea of, you know, what makes an API a public API, you know, a set of conventions defining what, you know, what would constitute public access.

So, first off I think all of you understand it's, you know, it's not...it does imply that data is exposed without regard to privacy and security but it does mean that there are legal and business considerations that have to be addressed before any given healthcare provider or vendor would allow another party to use the API to access information much in the same way to the extent that, you know, vendors like Epic, Cerner, athenahealth have APIs today there are legal and policy arrangements that surround that and surround access to it much in the same way that Amazon, Twitter, Facebook, E-Bay, PayPal also have those kinds of legal and policy frameworks around their public APIs that they expose for, you know, for a variety of use cases.

So, with public and the public API that the means...and there is, you know, a couple of, you know, sort of things here that we thought were important concepts that would constitute the definition of a public API. That the means for interfacing to it are uniformly available meaning that whoever is exposing the API doesn't say, I will expose it to you and not expose it to you. That they are uniformly available in that sense or at least in specification and the ability to interface to it or that it's based on non-proprietary standards, that it's tested for conformance by trusted third-parties in this case it could be the, you know, the federally sanctioned certification process, it doesn't have to be, but something that has some market validity.

And that finally it's well-defined, fairly applied and that business and legal frameworks, you know, that there are, sorry that there are well-defined fairly applied business and legal frameworks for using the API, which, you know, is if you look at, you know, a lot of other industries that, you know, sort of is the litmus test for a bunch of these things or the ability to have, you know, regular routinized business and legal frameworks for being able to access information through an exposed public API.

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

This...

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

So, let me pause here. Yes, go ahead.

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

This is Kitt Winter again, our main challenge with this recommendation is that it limits access to only clinical and financial systems and we would recommend, I mean, particularly with SSA that clinical and financial systems be removed from the recommendation as to not limit the type of stakeholder that could be involved in accessing or sharing the information.

I mean, it details under the recommendation that there is, as you just said, the legal and business consideration that needs to be addressed before sharing of information with another party could occur which should really cover a broader type of stakeholders involved in interoperability and not just limit it to the clinical and financial systems.

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

Yeah, no, I think, that's a fair point Kate and we...you know, we can't change these recommendations because they've already been approved but I think we were actually...we broadened this to...because the JASON Report focuses on EHR systems and so we tried to make it, you know, very broad by saying, no we're talking about clinical and financial systems but that is a good point that even that definition maybe too limited.

So, we didn't have any intent of limiting it in that way to just clinical and financial systems. The intent was for it to be very broad. That's something we can clarify in the inputs to the ONC interoperability roadmap.

**Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration**

And that would be good just to take out that language so it's really anybody.

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

Yes.

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

This is David, the one, you know, sub-regulatory concern to leverage, the new word I learned today is that, you know, the certification and incentives may be limited to subsets of the total space of people who could take advantage of or use the public API.

So, I agree with your notion of broadening the scope but not...it might not apply, not everything we are suggesting would apply to every potential user of the public API there may be some that are just not relevant to the certification program or to any particular incentive program. But your point is still valid.

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

Other thoughts and David while you're on the phone still any other comments you would add in the public API description?

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

No, I think we've covered it pretty well. We're getting there.

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

Yes. All right, let's move to the next slide, please. I'm just looking at the clock here we've got 10 minutes left.

So, the idea, and this is getting a little bit I think at Carl your concern, but, you know, by definition the Task Force couldn't resolve all of these issues or, you know, get it to the level of quality and to the level of specificity that, you know, I fully agree that we need, but this is, you know, sort of recognizing that this is a problem so that did not go unnoticed and the idea here is to say, well what are the priority API services then, you've got to constrain it in a way that will make it feasible while at the same time having it be meaningful and not just make work.

So, the idea is now to define a set of core data services and profiles that would define the minimal data and document types supported by all public APIs and the idea is we'd start with something narrow and for certification purposes that would grow over time according to, you know, sort of use cases defined by, you know, sort of a FACA process or a public/private process but that would...the anticipation would be that the market just expands those according to what the market finds valuable, right, there is not constraints on it in terms of what the market does, the market will do what it finds valuable.

But, you know, as we said, so in terms of the constraints from a HITECH perspective, you know, our thought was that HITECH should focus initially on what we call clinician to clinician exchange and consumer access use cases as the first implementation, you know, sort of specification. Again, could we mute our phones, please, for those on the call unless you're going to say something?

So, the idea of the core data services would be to enable ultimately, to enable, again, this isn't saying that out of the gate you have read/write access, you know, to both clinical documents and all discrete clinical data elements, right, this is saying that in the future enabling read/write access to both clinical documents as well as discrete clinical data elements and the idea is constrain that, you know, initially to be able to get something that is feasible.

So, the initial focus areas that we identified as what we thought would be initial focus areas for the industry, again, this is just being a little bit more...it's not being prescriptive it's being descriptive more than anything else saying, as we look across the market we think that these are categories of use cases that would be valuable as focus areas but we're not suggesting that they be limited to these.

As I said from a HITECH perspective, you know, as I'll discuss in a second, so, we, you know, put these in high-level categories, clinician to clinician exchange, consumer access, what we call pluggable Apps for consumers and for clinicians, population health and research, and then administrative transactions which are, you know, broad categories obviously but we just wanted to flag that, you know, there is a wide spectrum of, you know, areas here that we would anticipate that people would grab onto and run with. So, next slide.

**Carl D. Dvorak – President – Epic Systems**

Is this...

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

Oh, sorry?

**Carl D. Dvorak – President – Epic Systems**

Is this intended...this is Carl, is this intended to be under the timeline of Meaningful Use Stage 3?

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

No, let me get to the next slide Carl and we'll talk about that, yes, next slide, please. So, this is...so this is getting a little bit more at your questions. The idea of the profiles and then I think probably everyone on the phone is probably fairly familiar with the idea of, you know, resources and services, and profiles.

The idea is that the profiles that tightly specify data elements and formats used in the core data services and then our recommendation for HITECH, which is, you know, related to Meaningful Use Stage 3 and associated certification taking Brian's point that, you know, that certification and Meaningful Use are now decoupled so they don't necessarily have to follow in lock step but we would anticipate you want, as we described in our number one recommendation, there is an orchestration here that you want to be able to have happen. So it would be nice if the timing of that was as clearly orchestrated and closely orchestrated as possible.

But the focus areas we're recommending are one clinician to clinician exchange where, you know, the idea would be to compliment current document-centric approaches that exist in the market today perhaps with some very specific use cases related to transitions of care for example, you know, could be one and again, you know, this is something to be further defined.

And then the other focus area that we would recommend is the consumer access one for a number of reasons, one is that, you know, we believe there is a natural extension of view, download, transmit and Blue Button but really the second point leveraging existing account services so the extent that you have vendors that, and others, you know, payers, others who have, you know, who have provisioned both portals and applications, mobile applications and others for patients to be able to access that a public API built on top of that could be something that could extend those services and be deployed rather quickly because it doesn't have to, you know, sort of deal with all these issues of identity proofing, authentication, creating accounts and, you know, managing patient user accounts.

And this also...enabling the consumer access side of this as a part of this initial specification opens an avenue of growth from mHealth and public pluggable Apps that frankly could be, you know, the real source of a lot of development and experimentation in the market because those vendors, as we know, don't have a lot of the issues related to, you know, large legacy installed-base, you know, that they need to transform over time and so that might be a, you know, real source of development and activity that could lead to a lot of the market experimentation we need to get this to mature and to iron out a lot of the wrinkles that we know where they are ahead of us.

Let me pause here and take...you know Carl I think you were asking about this. I know it's not as specific as you might like but, you know, that's as far as we could get through this process.

**Carl D. Dvorak – President – Epic Systems**

I don't...

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

This is Shelly Spiro, I do have a comment on this particular slide, was there any discussion on adding registries as a third bullet? I mean clinician to clinician exchange is sort of that but registries are a little bit different, we see this with, you know, the prescription drug monitoring programs, with immunizations and other areas so is that also inclusive in this it just isn't called out or am I just assuming it?

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

You know I don't think we discussed it. I don't think that we anticipated that that would be one of the use cases, but again, that's...you know, our idea here was to identify these two and for, you know, the further work to more fully specify what would be feasible in the timeframes in the accelerated development process that we're talking about.

**Shelly Spiro – Executive Director – Pharmacy Health Information Technology Collaborative**

Well, the reason I'm saying that is because the immunizations and, you know, some of the others, that is work that is being done now and piloting now on, you know, getting the clinicians to interact with the registries both in clinical trials and some of the stuff that we're seeing on the pharmacy side.

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

This is Larry.

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

Go ahead Larry?

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

So, along that same line, you know, I have a concern that, you know, as these resources are being defined in order to satisfy the needs of clinician to clinician exchange and consumer access, and, you know, there are other things that these resources are going to need to do like reporting to registries, like administrative transactions, like research and if we...you know, they all need to be based on a model that satisfies all these needs and if we sort of launch with a limited scope of what the vision and model is, you know, the definitions with that are laid out there to satisfy the first two priorities here may have to change as we think about the other uses.

So, I almost wonder if, you know, if we really still, you know, as we go through the modeling stage whether we really need to have a much broader scope, you know, piloting maybe we don't need to do, you know, quite as broad, but I think you need to start, you know, the universe needs to be bigger, right, to get it.

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

Well, I mean, I think that's an interesting question. I mean, we did actually get this question at the meeting on October 15<sup>th</sup> that Charles Kennedy asked about this question of the data model and don't you need a data model and I think the answer is that the data model you build from the bottom up because it's too hard to build it from the top down.

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

I mean, a lot of work has been done for various aspects of the data models with version 3 of HL7 and, you know, a lot of that shouldn't get thrown away.

**Carl D. Dvorak – President – Epic Systems**

This is Carl Dvorak...

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

Yeah, well, I get that.

**Carl D. Dvorak – President – Epic Systems**

I think it's a lot more challenging than you might imagine and I think as you look at things like a prescription all the way across the spectrum to a TPN order you have to make sure that there is an agreed upon standard for representing an agreed upon standard for what makes a problem complete or a medication complete and I don't think the work that has been done in HL7 today provides enough of a roadmap for that, maybe it's a basis to do more work.

And Micky one more thing I was thinking. I wonder if we should ask ONC and CMS to lead by example and accept all attestation data and all quality measures by public APIs by Stage 3.

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

Yeah, I think that's a great point because that is one of the things we get to in six is that ONC and CMS should enable all of what they do through the public API concept. I agree with you.

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

Carl, I agree with you also and in terms of what's been done and what needs to be done my concern is you're going to either pay now or pay later. You have to address this stuff sooner or later.

**Carl D. Dvorak – President – Epic Systems**

Agreed, but I do think it's got to have industry cooperation...

**Wes Rishel – Independent Consultant**

And...

**Carl D. Dvorak – President – Epic Systems**

Or we'll just end up writing a lot of code that we end up throwing away later and reworking.

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

Right and that's not what we, you know, would want here and then that was the focus of...that was the idea of narrowing the focus and having accelerated development on something very specific that we think we can define because, you know, one of the things with standards development, as we know, is that it's never timeline constrained, right, the standards development process by its nature is to keep going until there is a sense from the participants and through the balloting process that it's done where we are talking about flipping the equation here and saying, let's define something narrowly enough that you can get it done within a certain timeline.

**Wes Rishel – Independent Consultant**

Micky, this is Wes.

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

Yes?

**Wes Rishel – Independent Consultant**

And I just want to point out that the work that's been going on that resembles the public API, that is to say FHIR, has been largely carried on by experts in the RIM who have had to work in the practical world and deal with the difficulties in implying a model that general to specific situations so as they focus on very specific subsets they're looking not to over simplify but to create a simple enough basis to deal with the specific issues. I mean, even as simple as what's the difference between a blood pressure and neonatal blood pressure and things like that.

So, the concern is not to repeat the last 10 years effort at top down maintenance but to take our learnings from that and apply it using a more focused approach.

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

Yes, thank you, that's well said. So, we are at the end of our time here so there is one recommendation left which is six, what I'm going to propose is that we take that up at the next meeting because...and that actually will work okay because that, you know, I think is more focused on sort of the governance aspects, I'm going to say governance with a small "g" and that will lead into, you know, sort of the discussion of the interoperability roadmap. So, I think that there is actually a nice dovetailing there that can happen.

So, I want to thank everyone first off for your engagement, that was a great discussion and I really appreciate all the feedback and we'll, you know, sort of take all the notes of this and I think these will be things that we can use as a part of our inputs into the interoperability roadmap as we begin that discussion at the next meeting. So, why don't I turn it over to Michelle for public comment?

**Public Comment**

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

Thanks, Micky. Operator, can you please open the lines?

**Caitlin Collins – Junior Project Manager – Altarum Institute**

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

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

Hey, it looks like we have no public comment. So, thank you everyone and we have another meeting coming up on October 29<sup>th</sup>, so next Wednesday.

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

Great. Thanks everyone.

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

Thank you.