

HIT Standards Committee Transcript February 20, 2013

ATTENDANCE

The following members attended the meeting:

- Jonathan Perlin
- John Halamka
- Dixie Baker
- Anne Castro
- Christopher Chute
- John Derr
- Floyd Eisenberg
- Jamie Ferguson
- Leslie Kelly Hall
- Stanley Huff
- Elizabeth Johnson
- Arien Malec
- David McCallie
- Wes Rishel
- Christopher Ross
- Walter Suarez
- Sharon Terry
- James Walker
- Lorraine Doo
- Ram Sriram for Charles Romine

The following members were absent:

- C. Martin Harris
- Kevin Hutchinson
- Rebecca Kush
- J. Marc Overhage
- Tim Cromwell
- Nancy Orvis

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you, good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT, this is the 45th meeting of the Health IT Standards Committee and this is a public meeting, there are two sessions for public comment built into the agenda one before lunch and then one at the end of the day before we adjourn and the meeting is also being transcribed so for the transcript if everyone can please remember to identify themselves when speaking. I'll now take roll call. Jonathan Perlin?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Here.

MacKenzie Robertson – Office of the National Coordinator

Good morning, Jon. John Halamka?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, John. Dixie Baker?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Dixie. Anne Castro.

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Anne. Chris Chute? I know I saw Chris earlier. John Derr?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, John. Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Floyd. Jamie Ferguson?

Jamie Ferguson – Vice President, Fellow - Kaiser Permanente, Institute for Health Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jamie. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President – Healthwise

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. Martin Harris? Stanley Huff?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer - Intermountain Healthcare

Present on the phone.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Stanley. Kevin Hutchinson? Liz Johnson?

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President – Tenet Healthcare Corporation

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Liz. Becky Kush? Arien Malec?

Arien Malec – Vice President – RelayHealth Clinical Solutions

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Arien. David McCallie?

David McCallie, Jr., MD – Vice President – Cerner Corporation

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Marc Overhage? Wes Rishel?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Here, on the phone.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Wes. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Cris. Walter Suarez?

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Walter. Sharon Terry?

Sharon F. Terry, MA - President & Chief Executive Officer - Genetic Alliance

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Sharon. Jim Walker?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jim. Tim Cromwell? Lorraine Doo?

Lorraine Doo, MSWA, MPH – Senior Policy Advisor - Centers for Medicare & Medicaid Services – Health and Human Services

Present, on the phone.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Lorraine. Nancy Orvis? And, I believe we have an alternate for Charles Romine, Ram Sriram?

Ram Sriram – Chief, Software & Systems Division - National Institute of Standards and Technology

Yes, here.

MacKenzie Robertson – Office of the National Coordinator

Thank you. And with that I will turn the agenda over to Dr. Mostashari for some opening remarks.

Farzad Mostashari, MD, ScM – Health and Human Services – Office of the National Coordinator for Health Information Technology

Thank you. We're meeting today and on the agenda is looking at the work plan for the Standards Committee for the year to come as well as reviewing the responses to the Health IT Policy Committee's Request for Comment on Stage 3.

And I must acknowledge and recognize that for many who hear about us talking about Stage 3 there is a sense of being overwhelmed that they're still trying to get Stage 1 completed or they're trying to wrap their minds around the significant push that is contained in Stage 2.

And when they...and I think we saw this reflected in the comments, when they hear discussion of Stage 3 and, you know, we're talking about, you know, 2016, there's the sense of "oh, my gosh, I can't even think about that." So, I just want to kind of recognize that while one of the important functions that our FACA's serve is to provide a measure of predictability and kind of long-term forecasting, that doesn't do you as much good if people have no capacity to be looking five years down the road. They're just trying to figure out what they're doing the next year or two.

And it is really, I think, important for us to know where we're going, to be planning, but it's also important to recognize where we are right now. The work that we're doing collectively around interoperability and exchange, based on what we already have in Stage 2, which is going to come in the 2014 edition software and figuring out all the workflows and the process redesign to make the greatest use of that, figuring out all the challenges, now we have the standards and now what, you know, the implementation, the inevitable challenges when you implement and finding out that, oh, you interpreted the consolidated CDA this way and I interpreted it this way, and, oh, we didn't realize that this trust anchor thing for the certificates, if you have the dual use case, all those detailed issues are going to be the work of the community in 2013.

That's what is going to be the story for 2013, 2013 is the implement...if, you know, 2011 and 2012 was the implementation of Stage 1 and adoption, and beginning to understand the workflows and process redesign needed to successfully use those tools for population health management, 2013 and 2014 is going to be about the implementation of information exchange and interoperability and figuring out, again, the process redesign, the cultural changes, the workflow innovations that are needed to support that to capture that information to resolve the inevitable problems that will come up and working as a community to understand the issues, to find, as Doug calls it patches, fix the dot releases.

Get forward progress on what is the potential that's already done, it's in Stage 2 and that potential is huge, not just for provider to provider communication but also for provider to patients and from patients to whoever, the new ecosystem that can be built out of that data and using those same tools as building blocks for other communications.

Time does not stand still and standards that are used will be, inevitably will be reused, hijacked, you know, and sometimes that may pain us to see, oh, my, but that consolidated CDA wasn't meant to be used for sending to a long-term care, right, but it will be and to figure out how to manage that and it's not going to be a top-down, you know, enterprise approach, it's going to be a little more fluid shall we say, but no less significant in the progress we make.

So, just want to set the stage for people who are going to be listening today, both in terms of the work plan for the Standards Committee as well as the comments about what we hope to be able to accomplish for Stage 3 to put that in the context that we need to sit back a bit and appreciate the work that has already gone into getting Stage 2 and also to gird ourselves for the sure battle to come in getting the most value out of what we already have established in Stage 2.

So, we move forward, it's always about implementation, not what we do in committee, but how that can serve folks in the community and with that, I turn it over to Jon.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thank you, Dr. Mostashari, thank you as always for the inspiration. Good morning. Great to see everybody here, hard to believe it's meeting number 45. I may look 45 meetings older you certainly don't, but indeed. It's really exciting and I note this, Farzad, because there's been so much accomplished and so much possibility that frankly did not exist as we began these discussions and in today's discussion we'll obviously talk about work plan and some of the comments, feedback on Stage 3, but before we do I just want to acknowledge a couple of folks who are here. Ram Sriram is here from NIST and maybe you might take a moment and introduce yourself?

Ram Sriram – Chief, Software & Systems Division - National Institute of Standards and Technology

Ram Sriram, I'm standing in for Chuck Romine and Kamie Roberts. I'm the Chief of the Software and Systems Division and one of the major products in my division is the testing infrastructure for health information technology.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, thank you for being here. I'm sure we'll have lots of questions and lots that you can contribute into the dialog. As we reflect on the content of today's agenda, that is the work plan and the comments in Stage 3 at one level it seems pretty formidable, but I want to come back to a word that, two words, that Farzad had used, the ecosystem and possibility.

And what strikes me for those of us who are experiencing this not at a policy level but actually in field, in the throes of implementation and living the experience. What's interesting is not only the actual message that is, you know, what's required to achieve sequentially Stage 1, Stage 2, the expectations that seem to be materializing for Stage 3, through what was planned, but the possibility and discovery that occurs around what hasn't been planned. Let me tell you a little bit what that looks like in our world.

What that looks like is an emerging set of data that begin to make themselves available for discovery, new uses of drugs, possible complications with drugs or devices. Insights into data that just weren't available before. It means that as we contemplate a patient's experience maybe we're not quite there with the workflow by virtue of the implementation stage of Meaningful Use but it does mean that data are there to be able to provide near real-time decision support understanding what might be most effective in the treatment of a patient or in fact what might be not only least effective but materially hazardous.

All these information points have been there but they've been latent, there's been no way to access those points of data in paper charts and so what does that mean in terms of expanding ecosystem of possibility? Well, you know, harmonization is sort of a term of art.

When we move the standards and interoperability we need data that actually can intersect with each other and form a more wholesome picture of a clinical context be it of a patient or population, or some subset in between and that's incredibly powerful as we open the doors for personalization that better support not only of patients as individuals but better support of a population or a cohort of patients with common characteristics. All of those are emerging possibilities.

Some of us are blessed with the resources to be able to tap into some of that latent potential with their own tools and resources, but what's also equally exciting, and Farzad was pointing out that we're...before the number of companies, individuals, entrepreneurs who are spawning up and offering solutions saying "hey, I know you have Product A, I know you have Product B by definition of the Health IT standards these are capabilities or intrinsic characteristics we believe we can fill Space C" and that's really exciting because it's the beginning of a new marketplace, a new ecosystem that also allows new possibilities.

These range from things that create social networks of frail individuals or even robust individuals who want to manage their health better. They create opportunities in terms of following patients longitudinally; they create opportunities in terms of providing services for providers who are working with not just in individual but a population of patients.

These are the new tools that become available and it also introduces a whole new cohort of new players some from out the mainstream of healthcare who are looking at solving problems creatively and in some instances, to use the Clay Christensen word, disruptively in contrast to some of the approaches that are going forward.

So, this is...I just want to share with you a sense of excitement, a sense of possibility. I know that at this table that there are those of us who want to make sure that these opportunities.

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

Reverberate.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Don't reverberate inappropriately and really part of what Dixie Baker has so eloquently referred to as a trust fabric that assures that information are always secure and appropriately private and a lot of good work that has been done.

There are all sorts of managerial responsibility, legal responsibility, regulatory responsibility and that's a part of this context as well but with good and thoughtful work and leadership, I believe that world can exist with the appropriate parameters for the protections that all of us would want for ourselves, our families, our communities, our society.

We also have the tools to create a new and better world that improves the safety, quality, efficiency and I would even say the compassion, the humanity of patient care and that's what keeps me excited as we enter meeting 45 and with that, one formal order of business, are there any amendments, modifications, corrections to the minutes?

Again, many thanks to the ONC team for, as always, capturing such complex dialogue with such fidelity. All the body language in the room is affirming agreement with the minutes. Many thanks for that we'll assume consensus on approval of that and with that let me turn to Dr. John Halamka to walk us through the work of today's agenda.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, well so last time we met we drafted just a few categories and themes around a possible work plan and it seemed very, very aggressive, there were many things on it that were speculative, it looked like a multiyear roadmap.

So, as Doug, today and with all the smart people at ONC in many discussions trying to craft a work plan outlines some of our next steps, one of the things you should understand is this isn't necessarily getting to an answer on every question, it's actually completely fine to say, well, on number one of course there are mature standards for Dixie's maturity characteristics, it's clear what the steps should be. Two, well there is absolutely not a glimmer in anyone's eye as to what those standards should be, but we can develop a few milestones as to how we might get to a standard.

So, when you start looking at it as a work plan don't feel like, oh, hey it's April 1 how come you don't have all four of these tucked and tied, if we can identify a process for making progress for some of them that is as good as getting to a complete answer and I think what's important is that every time I read a New York Times or Washington Post, or Huffington Post article that says there are no standards, there is no interoperability, you know, I cringe.

And, what you want is at least to have not necessarily every standard finished but a clear plan for how they will over time get finished and mature. So, understand Doug's presentation in that context and don't panic it'll be fine.

When I presented all of our themes to the Policy Committee a couple weeks ago I got a lot of positive feedback from members of the Policy Committee because what I transmitted was, you know, again Dixie you had a maturity of standards rubric and that moving forward with certain Stage 3 goals if there weren't mature standards or workflows, or they were overly prescriptive but hadn't actually yet been implemented anywhere and there wasn't efficacy demonstrated, you know, it might be premature.

So, I tried to present your views of balance, you know, pick a couple of key themes where standards have at least been piloted and then allow a little bit of latitude in how those things get implemented in Stage 3, you know, hopefully what we'll have is this balance guidance now digested by all the folks at ONC and the end result will be a perfect harmonization of the aspirations of the Policy Committee and the tough realities of implementation that we tried to bring in testimony.

So, we'll now hear from the public, which will be very interesting. I mean, we've all digested these aspirational goals, what did the public say? What did the vendors say? So, Jodi will present that, I look forward to that presentation.

Then after lunch I'll present the summary. Many of you were here for the HIE testimony that we gathered about what are the barriers, what are the enablers, how do we engage the consumer? So, I'll report out some key themes about Health Information Exchange acceleration and hear from Doug on ONC updates.

I recognize its February and so Doug I think one of the challenges is that we already have four goals for first quarter and we have only a virtual meeting next month. So, as I read the work plan and I hope you'll appreciate this, I think it outlines the right kinds of things for us to work on and if today is hearing from you to make sure we are focused on the right topics in the right order and ensuring that as we hear from the public about Policy Committee feedback that we are phasing our work and our timing in a rational way.

Then I look forward to not only the 45th meetings but the next 45 meetings in getting done all that needs to be done so the New York Times says, yes, interoperability works. That's the goal. I look forward to the meeting.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thank you John and with that, that is a perfect segue and it's a pleasure to introduce Doug Fridsma to put him as the first presenter of the order of the day. Doug has been incredibly gracious in terms of flexing in past times but, as John introduced, a robust agenda and glad to start with you Doug, thanks for your leadership.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Great, thank you. So, thank you very much for the introduction and what I wanted to do today, we have I think about an hour and a half to talk about the HIT Standards Committee 2013 work plan. I think what I'd like to do is give you a sense for where we are with some of the standards and interoperability framework activities and then the list of topics, the way that we organized this, this list of topics that we're going to go through over the course of the next 20 minutes or so all comes from you.

So, this is the list of topics that sort of came from the HIT Standards Committee. What we've tried to do is to say what would be the Workgroups that would probably want to tackle this problem? At what

point would we want to have the HIT Standards Committee as a whole comment on that work? And then also what are the kinds of goals that we want to get out of it, is it an assessment of the standards that are there, is it actual work that needs to be done, is it guidance or the like?

And so, to John's point, this was an activity that we started a couple of months ago. It had a couple of different iterations back and forth and I think as a result the Q1 activities, although queued up to be done by March probably are going to have to be changed. I see the work plan as really a living document that we need to continually revise and update as we go along, but I do think it will provide an opportunity for us to get out there some of the things that you guys have talked about and then to kind of work through how we're going to get some of that work done and to move things around as necessary to make sure that we get the work accomplished.

So, this is the classic multicolored S&I Framework portfolio snapshot. I think it's important to recognize that we are working very, very hard in a lot of these initiatives to find out what the long-term strategy is

for some of the things that started in the Standards and Interoperability Framework and figure out how we can maintain some of the momentum within those even though we're at a point where I think we're going to have rely on the community and this committee in a much larger way to try to advance the work that's going on.

If you take a look at the Direct Project, I mean, we've got that sort of in production and evaluation. ONC has been working very closely DirectTrust.org and some of the other participants in the community putting out fires as we identify problems.

It's important to recognize that one of the things that we are going to be, as Farzad has sort of mentioned, implementation of Meaningful Use Stage 2 is an important priority and there's going to be attention between the support for those things and our ability to do additional work as well and I think it's going to be important as these things build on one another that we are successful with Meaningful Use Stage 2 and can support that.

The transitions of care, we've completed the companion guides and we're trying to figure out a way to work in a maintenance mode with HL7 and other stakeholders to help sort of provide support for implementation with regard to that. The same is true about the laboratory results interface as well to make sure that we've got that information adequately supported so that people can be successful in implementing them.

The Query Health Project has a number of pilots that are underway. There's not a lot of active work that's going on per se in creating additional standards. There are the QRDA standards that have been published and HQMF is something that's been used not only in Query Health but also in Health eDecisions, those are in comment and reconciliation, much of that work has transitioned to some of the activities within Health eDecisions.

I'm hopeful that we can, as we think forward to Meaningful Use Stage 3 leverage some of the work that's gone on in Query Health, but it will be important to sort of balance that with some of the resources that we've got.

The data segmentation for privacy, that has funding that has come through other streams and so that work is continuing under Joy Pritt's leadership. There was an executive summary underway a series of pilots and I hope to get the group in front of this committee to tell you what they've been working on and the kinds of things that they've been working on with regard to data segmentation.

The public health reporting initiative is in collaboration with the CDC. One of the things that we're trying to do is to take the work that they've done identify where the low hanging fruit is and try to fold that work into some of the other activities and initiatives that are ongoing within the Standards and Interoperability Framework and we have some ongoing discussions right now within the CDC to see how we can leverage for example the structured data capture initiative as a way of moving that forward as we close out the public health reporting activities.

esMD is a project that has been in collaboration with CMS. They in large part are funding that, we are providing only a minimum level of support with regard to that, but it's an important area of activity particularly as we think about digital signatures and the ability to have non-repudiation from messages and information that's being sent around. It's also, I think, important for us in the long-term because I think there is a need for us to not create separation between administrative and payment transactions and those that are used to support clinical care.

Certainly, as we go to a framework in which we want to evaluate quality and pay for that, that means that we have to keep those two things connected. And so the esMD Project is going to be important because it is one those administrative kind of transactions and frankly they do a lot of work with fraud detection and getting waste and abuse out of the system and I think it's important for us to maintain some alliance and some connection there with the clinical activities.

The longitudinal care coordination has always been a community led initiative; it's been tremendous to see the amount of energy that's gone into that project as well. We have continued to try to support that at some relatively low level. I know that they've been working very, very hard to try to come up with activities related to care plans and care plan transitions.

We had a meeting about a year, a year and a half ago, if I remember right, and that was an area that we thought this group could really provide some leadership on and they've done a tremendous amount of good work there as well.

Laboratory orders interface, again this is an activity that is following on from the laboratory results interface. The ballot ended on 1/17 there's some ballot reconciliation that's going on and some early pilot work. Our hope is that there is a trifecta of standards that can be helpful in the way in which we manage labs.

There's a laboratory reporting initiative, a laboratory ordering and then sort of a compendium of orderables that I think is going to be an important part of that. That's all part of these initiatives. We're hopeful that we can sort of put a bow on those and get those out into pilot and see if we can move into more of a maintenance mode there as well.

Health eDecisions is an activity that is relatively active at this point. They have submitted an HL7 ballot in January, there are some examples that are in development right now and I think the goal there with the Health eDecisions is to see how we can make sure that we leverage some of our other standards like HQMF and QRDA to help support quality improvement not just quality measurement.

Automate Blue Button is an activity that we have had tremendous support from the Presidential Innovation Fellows assigned to ONC to move this forward. We have developed three working groups. We have also just recently published an implementation guide around the Automate Blue Button activities to try to provide some guidance about how to integrate our stack of standards by taking the consolidated CDA linking it into the work that's gone on an access to data that Blue Button provides and then providing an opportunity for people to transmit using Direct as part of this.

And this is an example of taking our building blocks in our portfolio, collecting them together and using that as a way of supporting new use cases. Structured data capture is the most recent initiative that we've launched that was just launched about three or four weeks ago. The goal here is just to provide sort of three different things from the community. The problem that we're trying to address is that as we get increasing need to have structured kinds of information captured as part of the electronic health record, it is going to be very, very challenging to make everything that you possibly could do with clinical research, the learning healthcare system, quality improvement activities, as well as local access to information all part of certification of the entire electronic health record.

It's going to be very, very challenging for us to get that kind of structured data in there. If you take a look at quality measures and adverse event reports and things like that we can start talking about thousands and thousands of criteria and data that would need to be part of an electronic health record.

What we have tried to do in the structure data capture is to say can we come up with a common syntax even if we don't come up with common definitions, at least a common syntax, for how people would describe these atomic data elements and in doing so provide the basic building blocks to assemble different data that needs to be collected as part of a work process and create a common way for electronic health records to access that information.

An example would be is if you wanted to use the electronic health record to help support clinical research activities, we can't certify an electronic health record to every possible data element that a clinical researcher might possibly want to collect; it's simply not a workable strategy.

But, if what we can do is get agreement on the syntax for what a common data element is and how you would assemble those into a document or into a container, if you will, to collect and make sure that every electronic health record has the ability to interact with that syntax it provides a common way for researchers to describe the data that they would like to collect.

I like to use the word not secondary use but supplemental, because what we want is we want to take data that's collected as part of clinical research supplement it with data that's collected as part of the electronic health record and together be able to get us to more robust ways of using that particular data.

I think the other thing that's important to note, and one final comment before we move onto the work plan, is that one of the things that's going to be important for us is to support implementations of Meaningful Use Stage 2. If you take a look at many of the standards that are in Meaningful Use Stage 2 they are draft standards for testing and use. They have not gone through normative ballots. They have not had years out there in the field to sort of debug them and they are considered draft standards for testing in use.

What that means is, is that over the course of the next few years we are going to have to make sure that we support implementations, identify where our standards need to be updated, where our testing infrastructure needs to be changed and where we can improve our technology infrastructure to get us to the interoperability that we all are looking for.

And so, that means that we need to be able to instrument the system, if you will, to be able to understand what's working and what's not and being able to triage that information to make sure that we are updating our implementation guides, our standards or even our testing approaches that will allow us to get to interoperability.

And, so it's an important part of our portfolio as we move from sort of what I call S&I Framework 1.0 to 2.0 we're going to spend more of our time on convening and getting the initial use cases defined. We're going to spend more of our time understanding what's working out there in the community. We're not going to be funding the pilots, it's something that's going to happen and that we need to make sure that we understand and can get that feedback to improve the process. So, any questions on that and then I'll move into the work plan activities?

M

Oh, I forgot I need my card...I applaud the work for this structure, data capture and my question is when Health eDecisions came up with a model of data that they wanted to use for decision support and it was somewhat different than what Query Health was working on, there is work going on in HL7 potentially to harmonized that, will this be a third thing that needs to be harmonized or is there a way to coordinate

so that model of information and the syntax can be coordinated around all, not secondary use, but supplemental use or whatever other term you want to put to it?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, the goal of the structure data capture is not to create an information model for how all those pieces fit together. I think if you look internationally at what other countries have done in trying to create more atomic level data elements, if you will, one of the things that is considered a best practice is to make sure that those things are integrated into existing taxonomies and vocabularies.

So, rather than coming up with your own name for a common data element link it into SNOMED or link it into LOINC or things like that. So, that provides a certain degree of structure around the semantics of what those common data elements might collect. That's slightly different than what an information model might allow you to do in terms of querying across multiple distributed systems or making sure that when you construct quality measures that we utilize it.

So, I don't see that the structure data capture would create that information model that is currently going on within the activities of Health eDecisions but one would hope that as we create those common data elements that can inform and be useful to the kinds of things that are going on within the Health eDecisions and the Query Health activities.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Jim Walker and then David McCallie.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Thanks, great work Doug. One might imagine that for each of these initiatives there have been three to five sort of key lessons learned identified and undoubtedly for all of them there are three to five sort of key challenges in play is that documented somewhere in that kind of really simple format?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

I think we have that information captured as part a lot of those initiatives. I don't think what we've done has been able to integrate that. I heard where you were going and I just put a little note down here that that would be a great thing for us to come back to this committee on. I don't promise I can do it by March but I'll add it to the work plan to take a look at that.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Because, I think that would really help inform us as we try to help you address these.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Sure and I think, you know, there are some things that I think we did well. I think there are some things that we could do better. I think we have made some of those updates and challenges going from S&I 1.0 to 2.0, but it might be useful to kind of come back in an organized way to say here's what we've learned, this is how we're making some changes and what works, what doesn't and what we're trying to address some of those issues, but that's a great suggestion, thank you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

David?

David McCallie, Jr., MD – Vice President – Cerner Corporation

Yes, thank you and Doug thanks for the summarizing of an awful lot of data really quickly. My concern is kind of generic but it's one we've talked about in the past which is I get nervous that some of these initiatives are perhaps not as tied to the vendor community as they should be in terms of engagement and sponsorship if you would. Some of them like the esMD or I'm sorry the Health eDecisions one, you know, got a fair amount of criticism in our review of the proposed Meaningful Use Stage 3 behaviors, you know, questions as to whether the whole approach made sense or not of pulling down and bloating a decision-support rule into an EMR, you know, as a compilable piece of software whether that would actually fit anybody's actual real world EMR implementation.

And I just...I see the structured data capture and I guess I get nervous that we might have a repeat of that, that, you know, it's yet another complicated standard for wrapping data elements together that isn't driven by somebody's pressing need and I admit I haven't put the time to dive deep into these areas to study them, and I should, so I make this comment with, you know, a little bit of embarrassment that I haven't done my own homework.

But, I just want to register the thought that they really need a sponsor or two from the major vendors to make sure they're on track with kind of practical reality. So, it's just a...I'll just register that concern. I know that's in a voluntary organization you need somebody to step up and do it but at the same time if it doesn't happen you may end up producing something that isn't very useful even though it was all done with volunteers.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, two comments, the first is that much of this work is based on a pilot that was done by Greenway about two years ago that leveraged the IHE profile called request form for data capture. So, this is based on an IG profile that the vendors have been engaged on. There have been vendors that have actually piloted this in the past and in fact, this we believe is going to be a generalizable approach that will be perhaps easier for the vendors to do than to take everything as a one off, whether it's adverse event reporting, clinical improvement activities or clinical research activities.

So, we have tried to listen to the comments that you've made over the course of the last couple of months to engage the vendor community in a broader way, this is based on existing standards that have been already been balloted through IHE.

What we need is we need a broader engagement to make sure that this meets the needs of the research community, that it meets the needs of the other folks that are there as well. We've been working very closely with CDISC, which is one of the clinical research activities, they support PhRMA. There's a whole bunch of folks there in the clinical research organizations that are also working on this.

So, we have tried to at every stage engage them and to make sure that this is not based on pie in the sky but in fact tangible real things that people are working on.

David McCallie, Jr., MD – Vice President – Cerner Corporation

And that's great to hear, just to follow up on that, because two of my questions were going to be about CDISC and how it differed from the work they've done and how it differs from the IHE profile which a couple of the vendors have implemented. So, I'm glad to hear that it's connected to that work. I hope it's addressing perceived gaps in that work, but I'm more assured than I was five minutes ago. So, thank you.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Yeah, there are a whole host of other initiatives as well that have tried to tackle very similar problems and so in a community driven process like this we will sort of tee up what we think are going to be relevant standards to take a look at and certainly we've had a number of conversations with Becky Kush who serves on this committee as well as with others to make sure that we are aligned with folks that have, one used these standards before and that it meets the needs of what they need to have happen.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, David and Doug. Let's go to Dr. Mostashari please?

Farzad Mostashari, MD, ScM – Health and Human Services – Office of the National Coordinator for Health Information Technology

Just a comment on that, I think one of the scenarios we find ourselves in is where there has been prior work to solve very specific problems in the past and with very specific standards or implementations and the number of those can expand infinitely of very specific use cases that solve real problems for people and in fact there may be real solutions to.

I think one of the...but it may not be scalable, and the work involved may be non-sustainable to keep all of those different profiles up-to-date and I think one of the things that we do have an opportunity to do is to step back a bit and say all of these issues are trying to solve similar problems and could we think of a little bit more of a generalizable approach to these class of issues for which each of the specific examples then become a different template or a different implementation guide off of the broader standards.

So, that I think is...everyone who is embedded in their own approach to this and at worse yet has already implemented a very specific approach to a very specific problem may not be immediately see the need, but I think if you look at it from, you know, the broader perspective you can see the need that there are real needs, there's a multitude of real needs, but how can we build this in a way that serves not just one specific use case but a number of use cases, that's in the best case, that's where activities like this fit in, in my view.

David McCallie, Jr., MD – Vice President – Cerner Corporation

And I appreciate that and these maybe exactly right, and like I say I apologize for not having done enough of my homework to be more precise, but I'm anxious that we not use the tail end of the last approach to building standards to build, you know, the last unusable set of standards that are derivative from complex things like the CDA.

When there's a completely new approach emerging are these problems so pressing that they need to be solved with the last standards or should we be focusing on better approaches. You know, these QRDA and the other standards they're incredibly cumbersome and they are built on the CDA or on the CDA model that is disappearing from the future.

I mean with the FHIR work anyone who sees that immediately perceives how much better approach that is than some of the older CDA work, it's so much less complex, a lot of the crust that doesn't add any value is removed from the definition to the messages.

I get nervous that we are building the tail end of the last standard instead of the beginning of a new set of standards and that's a broad rubric and it may not apply to either of the two that I've singled out, but, you know, when the vendors are so busy with Stage 2, rightfully so because it's so important, and they're not paying close attention to this and it's being driven by people who live in the old world of CDA-based standard we may get the last CDA standard and it will not be the best we can do.

And I don't know how to fix that, I don't know, Arienne, you and I have talked about this a little bit and it's a manpower challenge, it's, you know, focused energy, but I sense that HL7 is really changing and on the cusp of a completely new way to think about these things with FHIR and use of JSON and SOAP or OAuth and other approaches that are much less complicated, much more appropriate to the Internet era than the IHE profiles at SOAP stack and we've talked about ad nauseam for the last 44 meetings. But, you know, that shift has happened and it's not going back.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, David, I think your point is taken and I'm not sure it's incompatible with what I understand the broader point to be which is really John Halamka's favorite word the principle of parsimony, that, you know, we as we address a number of use cases rather than the unique solution what sort of common thread can support this multiple use case and superimposed on this dialogue is how that is achieved and appreciate that thread of points.

Let's just in the sake of...I want to be sensitive to time and if there are any comments specifically on this point and limit it to that point and very focused I'll take those comments. I know that Wes Rishel is online, his virtual card is up, I want to make sure he's not in contempt of court as he has had jury duty. So, we're going to come to him very quickly. So, very brief comments just to this point. Dixie?

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

Yeah, exactly to this point is that first of all I'm really pleased to hear Doug mention that they're looking for structure data capture at RSD, which is retrieve form for data capture.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Retrieve form, thank you.

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

Yeah, but I think that what Farzad said, you know, we tried to do exactly that several years ago with RSD when I was doing some work with CDC, because RSD was developed for retrieving data for research and we wanted to use exactly the same standards, RSD, to retrieve form for public health reporting and we also looked at adverse drug reactions.

We tried to do the exact same thing but I think that because we were trying to do it from CDC and we were...it didn't really go anywhere but I think it does have to come from ONC to show that we have a standard here that can be used for public health, can be used for research, can be used for adverse drug events. So, I'm really pleased to see that this is the direction you're going.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks and just on this point, we'll come back to the other points, but just on this point, Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President – Healthwise

Yes, just on this point for structure data capture not to forget we have a new group who could be entering data as a new source not from the EHR and that's the patient specifically. So, to David's point, you know, not automating hell how do we get to a more advanced look and have parsimony between data capture that could be coming directly from a patient or an EHR so that we're not, you know, we're being more advanced. So, I'd love to hear a comment on that and maybe off-line, but not to forget that.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

And Floyd, just on this point?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Yes, a quick follow-up, so I appreciate Dixie's commenting that CDC actually had used that. There are some additional profiles in IHE dealing with redaction so that only the information needed is there, but I think that having this new group look at these existing profiles will be a good thing to help address the issues of unneeded complexity, but I think they...I know they were originally intended to be used beyond research but for any kind of data capture and for forms basically.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great. Great conversation. I think that's very helpful in terms of flushing out the considerations for Doug and appreciate everyone's comments on that. Let's go to Wes Rishel, you've done this theme, where on the final theme because I do want to also make sure we leave enough time for some dive into the plan details around each of these threads that Doug has outlined. So, Wes?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Thanks, Jon. On the topic that has just been under discussion...

M

Tell him to shut it off.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well, I was waiting.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

All right Wes, we're going to...

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Waiting for my turn.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Assume that you aren't in court and that you're still a free citizen. We'll come back to you if you weigh in again. Any other comments before Doug resumes this thread. All right then Doug why we let you get into some of the details of these topics.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Great, thank you. So, what I want to do is just articulate the activities that were on the list that you guys have been working on the last couple of months, talk a little bit about what the Workgroup and the HIT Standards Committee might need to do with this. This is the beginning of the conversation it's not the end. I think the other thing that's important to recognize is that we have on occasion within this group talked about, well what we can work on and what can we not work on, because we've got Meaningful Use Stage 3 coming up so we can only work on X and we can't work on Y.

I think what's important to recognize is that we can work on all of this stuff, you know, Meaningful Use Stage 3 is not the end, it's a milestone on the way towards getting towards interoperability. There are other, you know, there are other possibilities for rules in the future, there are other kinds of regulations that we can think about engaging in.

And I think our job is to be very thoughtful in how we begin to chip away at the technical infrastructure that will support the policies and the regulations that are out there.

So, in presenting this we've tried to put it into buckets, if you will, quarter 1, 2, 3, 4, 5 and 6. We've gone beyond just a year, because I think it's important for us to recognize that this isn't a sprint to Meaningful Use Stage 3. This is a long-term engagement in achieving interoperability of which Meaningful Use Stage 3 is an important milestone that we need to consider.

So, with that let's get into the work plan. I just want to go through this very quickly. You guys will have an opportunity to flip through.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

We had a technical glitch and Wes is on the line, so, right before we dive in if we can get Wes's brief comment.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Sure.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Perhaps even facilitating transition into the details. Wes are you there?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes, I don't know why, you didn't hear me before, was that right?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

No.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Oh, okay. So, I guess you're trying to tie off structure data capture I understand that. I do want to reinforce...I mean I've thought a lot about these issues of how a standards program that is basically built on every other year deliverables can ever introduce any fundamental improvements into the underlying technologies. It's hard to put out a set of proposed regulations that trust something that's pretty new and it's hard to ever build up the level of trust when the regulations don't include them.

I would highlight the comments that Dave made about a lot of preliminary work being underway both in FHIR and CIMI and coming along at a level that it should be considered and I would hate to have us say, well this group has been working on this and it was...it's all done and we just don't have the time to consider a better approach. On esMD I understand it is basically about CMS requests for information post hoc supporting a claim, is that correct?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

That's correct, that's correct.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, so that relationship seems to be one that has a lot of potential for development and has potential even to replace existing workflows where great volumes of medical data is submitted often with paper claims right now. I think it would be worth our having a chance to hear more about it at a future meeting.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Sure and so I'll add that to the list perhaps a deeper dive around structure data capture and around esMD. The activities of esMD, one of their principle barriers has been to have a digital author of record recorded in terms of the documents that get sent back and forth, that's an important functionality that we think is generalizable and so that's one of the things that we think is sort of an important aspect moving forward.

The other things is that esMD is interested in structure data capture because they would love to do preauthorization on some expensive tests, it would be great if they could collect that data in an structured way and so they're also looking with interest at the ability to say have a couple of structured data elements that would then be recorded in the electronic health record as part of the structure data activities. So, I would be happy to provide that as an update in the future meeting.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, just let me add, in particular a whole lot of work has done in that regard in combination of HL7 and X12 going back over 10 years now and it was a bit disappointing that esMD apparently didn't give any consideration to it and part of the work was involved in being able to sort of have a level of structure that grew over time as opposed to being fixed in a regulation and unchangeable, and if they're now saying, oh, what we need now is to add structured data it's particularly...it will be particularly unfortunate if they don't go back and revisit the last 10 years worth of work in that area.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Okay.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

And, Doug, I just want to make sure we give you the adequate time to dive into the details and we'll pick up.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, I'm going to run through this really fast because I know you guys are flipping back and forth I can see you on the various pages writing notes and comments on the things that you would like to talk about. So, the sooner I can stop talking and the sooner you can start talking probably that will relieve the tension we have in the room.

So, the first things is, is that when it comes to Q1 we've got four things that are listed here. What we tried to do in looking through the work process is to try to pick, you know, 4-6 different things to tackle each quarter figuring we could do one to two things each of the meetings and if you've got three meetings that works out to be, you know, at most about six and, you know, if you're doing one at a time you've got about three that you can do.

So, it's important for us to sort of think about how we were trying to scale this out. I think one of the things that we also need to think about is that it maybe that we need to have some activities that are ongoing within the Workgroups that will help us so that this group can be a decision-making body and the deliberations are going to happen in the Workgroup and so we've tried to identify those Workgroups that might be able to help us with that.

So, the first one is additional standards to support transport of data to and from patients and so one of the activities there is to engage the Power Team and perhaps the Privacy and Security Team. One of the things that the NWHIN Power Team talked about before was to expand the kinds of transport standards that were out there.

We adopted Direct because we thought that was a path of least regret. We also said we need to simplify some of the web services approaches and, gee wouldn't it be great if we had some RESTful approaches as well. So, I think there needs to be some discussion there with some final recommendations and requests.

I think perhaps in March we can have some limited time for discussion and we may need to push that out a little bit, I'm looking at Dixie right now with regard to those kinds of things. But, I think it's important for us to revisit the recommendations of the NWHIN Power Team and some of those may be, this is how we think we should proceed not so much this is the standard that you should adopt and that would be a helpful thing for us to have a conversation. I just don't want that to get lost.

Number two is standards to support image exchange. I think our assessment of a lot of the work with image exchange is that we need to have a better scope and requirements in terms of what this means with regard to image. Is this the full compendium Avoxyl that you need for cancer staging and treatment or is it a JPEG that you would share with your patient that is of high enough resolution that your iPad and/or your smart phone can look at it and you want to use it as a conversation with the patient.

And the thing is, is that there's a whole host of different standards that are accessible out there and different ways that we can approach but I think we need to get clarity about what is the use case that we want to try to tackle next and not get ourselves into a we need to turn every EHR into a PAC machine versus we're just going to put a JPEG out there on the web.

And so, I think this is why Clinical Operations, the Consumer Patient Engagement Power Team also needs to be engaged because I think that's an area that we need to consider and so what we need is we need to have discussion of the existing image standards but in the context of what of the variety of use cases that are out there we want to achieve and it maybe that it's more than one, it might be here's what we want to do for patients, here's what we want to do for providers, here's what we want to do for radiologists and we just need to break that down and I think having some discussions in the work teams to get clarity will help us understand the path forward.

Number three is a big one, standards to adjust current content gaps, which is HL7 version 2 lab orders, formulary, downloads, canceling transactions needed for hospital discharge medication, ePrescribing representing general genomic data in the EHR. Clinical Operations is probably the Workgroup most able to do that.

Some of this requires us to tee up what we've done in the Standards and Interoperability Framework, some of it will require some additional work that needs to be done, but I think that group can help us articulate our way through that and help us identify what's ready, what do we need to continue work and how can we a path that will get us there.

Standards for security of data at rest especially genomic data and consumer downloads. Privacy and Security, you know, the Tiger Team and Clinical Operations. We don't have a lot of time for discussion and maybe we need to do this later in the quarter or in quarter two, but I think it's important for us to take a look at what would be the appropriate standards that we need to take a look at and what would be the recommendations to provide not a lot of say additional work but just a review and if based on that review we need to do some other things that would be helpful.

Going onto the next one, let's see, improvements in the consolidated CDA standard to facilitate unambiguous parsing, longitudinal record sharing and bulk record sharing. Again, we sort of, you can see the Clinical Operations has a bunch of assignments that we thought about with this. I think there's the need to get the LCC in front of the HIT Policy Committee and the Standards Committee so that we can give an update on the activities that are gone on there.

I think one of the things that we have to think about is the consolidated CDA has created a series of templates and segments, and sections that we need to look at and see if there's particularly some small incremental work that can expand the usefulness of that, maybe there's a new section that needs to be constructed that helps us with long-term care that can leverage many of the other sections. Maybe there's a way that we can take shared care plans for example and create computable segments that would be then incorporated in a consolidated CDA. And so I think part of this is an update of where we are now and then I think there's additional work that may need to be done.

I think the third thing is that this is going to be an ongoing topic as we get implementation of a consolidated CDA standard out there we will see what works and what doesn't and I think that's going to be also an important aspect of what we want to do. Everybody's cards just flew up. Do you want me to keep going or do you want us to take these questions as they come up?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

I'll tell you what let's keep going because you're at probably more than the halfway point and a number of these things I think are going to thread across the different time horizons. So, we'll answer the questions in bulk.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, everybody write it down and we'll get to it. Standards to record advance directives and care preferences, Clinical Operations, I guess there's a scope discussion that's needed there, you know, do we need to have the full standard for that? Do we need to have an indicator that such a thing exists? Do we need to have a link to where that content would exist? So, I think having some discussion about what that looks like I think is going to be important as well as we go forward.

Number three, standards for application programming interfaces to support modular application integration, now that's a big one, but it's an important one and it may be that as part of the work that we're doing on the structure data capture or what I like to call this notion of a data spigot, the ability to have a way of opening a spigot into your EHR and pouring out the data that is in there already.

Are there ways that we can create a way of having an API into an EHR that provides some extension of our existing standards? So, for example, can we query using something that looks like HQMF or some simplified version of certain kinds of questions you can ask and what you get out is a consolidated CDA or a QRDA Cat 1, or whatever it is.

But, I think we need some discussions about what would be an appropriate scope for that and how we might be able to proceed if that was the case. Standards which support flexible platforms for measuring and reporting quality and quality initiatives, that's I guess in the Clinical Quality although aren't you guys renamed the Clinical Improvement Workgroup or did we not decide to do that?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

I thought we were still Quality, I don't know.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

You guys are always going to be Quality Improvement or Measurement otherwise it's all there.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Just let me know.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Okay, just make sure that you're doing both measurement and improvement that's all I ask. So, this maybe just an update from the HeD work on HQMF, QRDA some of the work that's gone on in Query Health and the data model harmonization. It just would be a good thing for the Clinical Quality Group to actually address all of those things and help us chart a path for how best to leverage the building blocks that are out there.

If we go to the next one, 5, 6 and 7. Q2 is going to be busy for you guys I hope you've cleared your plates. Standards for clinical decision support, knowledge representations and application interfaces for a query response, this is really just an update on the HeD activity. So you can take 4 and 5 and combine those together. I think there's some concentrated effort that needs to happen within the Workgroup to sort of chart a path through that and present that back to this group and see if we can provide some input.

Standards which support defect reporting to patient safety organizations. This is something that I think fits into this structure data capture initiative. So, we've been working with AHRQ within the structure data capture to see how we can use their common format and identify those common data elements in a syntax for that, that would allow a provider to enter information that would be sent to a patient safety organization and that would be structured in a way that would conform to those specifications.

And then standards to support registries including structured data capture and transmission to third-party repositories, again that's your words not mine, but that fits into what we're trying to accomplish within this structured data capture activity. So, let's go to the third quarter, let me just make sure...

Farzad Mostashari, MD, ScM – Health and Human Services – Office of the National Coordinator for Health Information Technology

Doug, I have a question, just when we're identifying the Workgroups that will be involved in many of these S&I activities I think the...it's not just that they're going to be involved when this gets presented to the Standards Committee, right, presumably there will be ongoing involvement with the S&I activities so that any concerns are, you know, raised as part of that. Is that how's it's working or are we not getting enough participation from the Workgroup in the S&I itself?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Actually, this was more an attempt to move some of the activities out of S&I and into the Workgroups as we begin to sort of contract the activities within the Standards and Interoperability Framework, that's going to just create more...a different forum, if you will, for some of those discussions. So, this is an attempt to try to figure out a way and to assign some responsibilities for folks that will track it.

Now, those committees may come back and say, listen this is something that exceeds our capacity within our Workgroup and we need a broader input, that would be good input back to ONC to say, you know, for the Workgroup to be successful we need to have a different forum and that could be, again, moving things back into the S&I Framework, but I think the hope is, is that more of the burden is going to be charged with the HIT Standards Committee and the Workgroups that are here.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Farzad, directly to your point, Jim Walker, that will create a burden on staffing. My experience, at least, is that the Workgroup is capable of enormous and really remarkably rapid and thorough work but it will require staffing to sort of tee that up for us because nobody on the Workgroup, and I think it's probably true of the others or at least many of them, has the time and the focus to say, okay, we've got to do 1, 2, 3, 4, 5 and 6 and make sure that we follow-up on those in a timely schedule.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, Doug, I'm going to suggest that march on and I would ask the group as we move to a discussion section after this, think in three boxes. The first is in terms of the ramifications for a particular Workgroup and there may be other instances we're saying, well this is indeed centered around say Clinical Operations but they're also Liz and Cris and looking at you all there are implications for the Implementation Workgroup in terms of testing, etcetera in certification and testing. So, keep that as one bucket of thought.

Then the second bucket of thoughts as Doug finishes and we move to discussion think about the general comment that apply across standards and some of those we can anticipate. Some of these things are imminently doable and self-contained others are quite expansive and, you know, think about that set of a pan topic of issues.

And then if there are specific issues related to a topic let's try to address those in an organized fashion and we'll go sequentially through understanding that some things may thread across time. So, keep in mind that rubric and we'll turn back to Doug to walk through the third and fourth quarters and then we'll move to discussion.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, I'll try to speed things up a little bit. Standards to support closed loop referral, we think that in quarter three it would be good to get testimony from the State HIEs and update on the 360 pilots and discuss both lab and referrals there. Clinical Operations could be an area that could take that initially but then I think we may need to have a broader discussion as well.

Supporting record locator services, the Power Team and Privacy and Security I think the Information Exchange Organizations can provide testimony about how they do things and see if that can inform the conversation.

Query response of providers and patient identity in directories, Power Team and Privacy and Security, again, testimony about the HPD+ implementation there around directories and then to think a little bit about how we might support more targeted queries and create an incremental path to that query response.

Standards which support consent in a query response architecture such as granular patient and privacy preferences hosted in a managed service or send as part of a request for records. Again, this is a NwHIN Power Team and Privacy and Security and I think we need to focus on the standards for consent here first and there's a lot of work that could be done. We think that Q3 would be the appropriate time to sort of get our ducks in a row to talk about that.

Standards for recording care plans and care teams, we need a more detailed discussion on what goes in the care plan and who is part of the care plan. We believe that, you know, this is clinical operations but we need patient engagement. The patient is clearly a part of the care team. How do we figure out ways to both encourage that as well as to get to computable representations of these things?

Standards to support data segmentation for privacy, this is ongoing work out of Joy Pritt's office that we and OSD are supporting. We need an update on those initiatives and some recommendations from the HIT Standards Committee about how to proceed given the work and pilots that they've done.

Standards for clinical documentation to support new payment models including ICD-10, smart problem lists, computer assisted coding. We really need to discuss what innovations may already be happening and an update on devices and device integration is something that may fit into that.

Standards to support query of data within organizations and targeted queries for patient data. This is something that we can...I sort of break down these query or the incremental path into three kinds and I apologize, but there's a MyQuery, a targeted query and a distributed query and what I mean by that is MyQuery is it's my data, it's in the EHR I need to be able to query it.

Authentication, authorization are taken care of just being a part of that electronic health record system and no additional work is needed, but we need a standard to be able to provide that query and getting a response back that is structured or that is standardized.

Targeted query is someone outside of your organization who with appropriate authentication consent and authorization can remotely query your system in a targeted way to get back information; it's the same problem as MyQuery except you add onto it the authentication, authorization and sort of remoteness, if you will, about how that transaction would occur.

And then the final one is distributed query where you ask the same question to lots of other folks, that's where the work that's going on in developing information models about the questions that you can ask are important so you can build from MyQuery to targeted query to distributed query by kind of linking together standards for asking the questions, standards for getting appropriate authentication and authorization, and then standards for information models so that there is consistency in the semantics of what you might ask. So, we should have additional conversations probably in clinical quality and clinical operations.

Last two, first is going to be standards to support measurement of EHR usability. This is something that I think we need to have a discussion here but we don't think about these as standards in the traditional technical sense, but how do we do that sort of assessment and Jacob Reider and his team really are going to be the leads I think on this, but we want to make sure that that gets in front of this group and we have a conversation about it.

Standards to support representation of patient generated data including consumer device data. We need to have some detailed conversations about that. This is going to require integration or coordination with FDA around the work they're doing on unique device identifiers and how that fits into this ecosystem. We also need to make sure that we think about what that architecture looks like. Do we want raw data from each of the devices to be standardized? Is the raw data going to go to a hub and at that point be transformed into things that can be incorporated into a personal health record or into the EHRs, those are the kinds of conversations that we need to have as well.

Standards to support data comparability across entities including detailed clinical models. This is CIMI, CDEs, other models that we need to think about. This is about thinking ahead to the semantic integration that we need to have, perhaps FHIR is something that can be added into this as well as we think about how to integrate these detailed clinical models and take a path of least regret as we move forward to getting additional work done.

Standards to support digital signatures that's the update from esMD. Standards to support certification criteria that anticipates broad NIST adoption, that's really kind of a Privacy and Security TBD. We need to have an update on some of those. And Standards to support query of data within the...actually that's a repeat; we're going to just do that twice.

The last one that we want to take a look at is standards which support redundant data identification and reduction. So, how do we uniquely identify each data element or how do we reduce data duplication in systems and that's something as we get increasing amounts of information exchange is something that we're going to have to take a look at.

And then standards to support consumer friendly terminology. Leslie, I'm putting that on there not because it's the least important because it's just last, I don't know, but I think it is important for us to think through about how to do that so that there are ways to have consumer friendly. We've got some terminologies that are provider friendly. We need to think about what that looks like in the consumer world as well and so that's I think another conversation that needs to happen.

So, you guys have your work cut out for you. You thought summer camp last year was tough, you know, this is more like boot camp and so lots of activities that are going to go on and I think it will be helpful for us to have a conversation about how we can best support the work that you're doing and ways that we can queue this up in a logical way that makes sense and grows one to the other.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, Doug, that was a very thoughtful overview again. We're going to sort of parse our discussion for efficiency into three topics. One sort of committee interest in that there are others that should be involved, come back to that in a moment and then sort of crosscutting and then specific and we'll move chronologically through understanding, again, that some of these are very self-contained and some feel much more open ended. John, I know you have some opening comments, John Halamka?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, again, as we have these discussions every project that we do in life is a function of scope, time and resources, right? So, as you look at this which is an extraordinary array of work, you know, are there things that we should reduce scope and as I said it's not necessarily the case that we have to have a definitive answer, we have discussion even if it just outlines milestones for getting to an answer that's a way of reducing scope.

Should we extend time? Should, you know, we look at this and say, well, Doug, this is all wonderful, this is actually a three-year plan, but as we said we're going to discuss them in this time frame but then end up back to you with a multiyear plan.

There are resources that we can bring to the table. So, it turns out Liz and Cris have just volunteered to collaborate with Clinical Operations join forces and be able to say, oh, well gee for certain things, like, oh, let's analyze whether or not image exchange with JPEG is a very easy thing to implement as opposed to every patient getting a DICOM reader, you know, okay, well they can provide some interesting input on that. So, that in effect, to the point you made Jim about staff, staff support or extra committee members providing additional resources. So, anyway, I look forward to discussions in the domains that you described.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, so let's start with one committee assignments. Cris and Liz, any additional comments on your volunteering, thank you very much.

Elizabeth Johnson, MS, FHIMMS, CPHIMS, RN-BC – Vice President – Tenet Healthcare Corporation

No, I don't think so. I think what we'll do, Doug, is we'll...and working with Jamie, we will determine where we can play at best and get that out so that it becomes part of the permanent plan.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, thanks. And Jim Walker, you made a very important point of the staffing issues and I know, Doug, really your team will have the ball in terms of the dynamic of ensuring that these topics and the depth of these topics are supported for the committees to deal with, the Workgroups to deal with adequately. Other comments on committee assignments, work process? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

So, I like...I hear Implementation Workgroup that sees a lot of overlap of Operations. I think I do as well and rather than being my usual type cast into quality, I think there's a lot of interaction between what goes on in the other Workgroups that needs to have some quality input so that there's not a retrofit later and especially with decision support and retrospective measurement. So, if there's a way to coordinate that in a more natural fashion it would be a lot easier.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, Doug with your and ONCs permission maybe we could have the Workgroup Chairs just by e-mail or call and parse out the interface issues. I'm sure...let me just apologize to everybody in advance, I'm sure it won't be perfect but we'll do our best and iterate to what is both we hope thoughtful and practical, manageable. We don't want everybody doing all of the work otherwise it would be inefficient. Doug?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Yeah, I just want...you know this is a draft, this was our best guess, but it provides fodder for that discussion and it's exactly what I hoped was going to happen which is get the folks together figure out ways that they can distribute the work and we can then help support and coordinate.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, good. Well, let's put the committee piece to bed, not to say we won't readdress these but now let's focus on content and again, let's parse it first on crosscutting and then we'll go chronologically by...so all those with crosscutting, move your cards forward. Jamie, your card couldn't go more forward.

Leslie Kelly Hall – Senior Vice President – Healthwise

I had a comment.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Oh, I'm sorry, one more on committee, Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President – Healthwise

Yes, the same concerns that Floyd had, but as we look at patient engagement and inclusion areas like advanced directives very, very important to patient preference and value is incredibly important, patients and shared decision-making, so, just I'd like further discussion about how do we make sure as we bring up this new context to our work how do we cross pollinate.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, Leslie Kelly Hall and John Derr?

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

I just want to make a comment on the LCC planning. I'm presenting to the Policy Committee in April. A number of you have asked me when we're going to give an update on LTPAC and I'd like to suggest that in April maybe there's time that we can take with the Policy and I can present to this committee so we're both in tune.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thank you, very much John. MacKenzie and team will see if that will indeed fit with the schedules, certainly hope that will work out. Okay, now anything else on committee activity? And, again, I promise you we won't get it perfect today. Walter Suarez?

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

Yeah, this is Walter Suarez, this is maybe a committee comment, committee level comment, but what I'm concerned about, and I assume this is certainly the long list of course of all the assignments, but when you put this in an entire year, some of the items, this is not an item that is a one meeting of the Workgroup, these are items that are a year-long work worth of the Workgroup. So, it takes multiple meetings of a Workgroup to address just the first one, additional standards to support transport data to and from patients.

So, when you begin to line that up across the year you begin to see how across quarters there is an additional set of items and then there's an additional set of items later on so at the end of the year you still have the work that you started at the beginning of the year with quarter one plus all the work that is coming up in the quarter 2, quarter 3, quarter 4.

So, I'm concerned that this is really overwhelming in many respects; it will require basically Workgroups to meet every week for the entire year to try to address many of the issues. Many of the issues are being addressed through the S&I initiative.

So, I just wanted to raise that concern because when you look it as a quarter by quarter, it gives the impression that, well we'll solve the standards to support image exchange in quarter one and then that's it. And then in quarter two, we'll just jump into standards to support, you know, defect reporting to PSO. So, it's really important to consider the effect of the progressive amount of work as it goes along, because really each of these items is a multi-month type of item.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

As to the comments that I made I think it's actually fair that the Workgroup Chairs push back to the ONC folks and say, you know, what it turns out in 2013 if we're going to do all this right, you know, we're going to just need more time on this stuff. So here is the timeframe by which we can get this stuff done. As, I say, either we choose to decrease scope which we could say or we choose to increase time and that's a very valid comment.

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

No, and the other part of course is that Meaningful Use Stage 3 is not yet in the picture because in this year probably we won't have the final rule for Meaningful Use Stage 3 necessarily, I don't maybe they will come out towards the end of the year, but at some point Meaningful Use Stage 3 will become a big priority because that's what we have to address, you know, the definition of the standards for Meaningful Use Stage 3.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Yeah, let me again, thank you for the work. I don't think the depth of the work is necessarily implied by the quarterly schedule, that's a very fair comment. John notes 2 dimensions. I think one of the first iterations of the Workgroup Chairs and Doug, and us, is in particular helping to put some parameters around how do you chunk the work and for greatest effectiveness what can be delivered early. Doug Fridsma?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, Walter, this is...I mean, I took the list that we got from the HIT Standards Committee. I think it's important to recognize that this is an ongoing activity. So, one of the things that I don't want to have happen is to say, oh, because we can't get this done by X we shouldn't do any work on it at all, because I think we need to continue to build.

I think our standards efforts should not be punctuated equilibrium, if you will, where there is this flurry of activity that happens just before a rule and then periods in which there's not a lot of evolution, if you will. I think we need to think about this as a deliberative ongoing conversation that we need to continually move forward and I think that's to your point, which is to say there is some stuff that's going to take us, it might take us three quarters to have that conversation, it might take us even longer to figure out a pilot or whatever once we've made those discussions.

Even if it takes us longer, it means that it's still valuable work that needs to be done and we have to just sort of balance that. So, getting feedback, you know, I could have taken this and I probably could have, in a more realistic, said here's a two year plan about what we need to do, but you guys are going to have to help to say, we think it's going to take us at least three months to have discussions and at the end of that we might have a decision about whether we can recommend a standard or that we want you guys to do some additional work on the standards and interoperability framework, that is fine.

That's the kind of conversation that I want to do, but I took the list that you guys did and I put it into a year and I said this is what we'd have to do. Now what we need to do is have that conversation to figure out what are the milestones, what are the things that we need to work on, how can we have this as an ongoing conversation rather than this punctuated equilibrium.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, great conversation, a lot of work on that. Let's go...is this still committee, Jamie? Yeah, okay. Now let's just go to the crosscutting issues.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

One on committee please?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

One on committee. Okay, two more on committee, Jim Walker and Dixie Baker.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

I have been stunned by the effectiveness of the Workgroups I've been in and their ability to bring remarkable expertise to very complex problems and sometimes to answer them fast. It seems to me that we need, as I think has been implied, but early and again with strong staffing support, to identify what are the critical questions the Workgroups need to ask and then sit down and say, okay, does that mean Liz and Cris and us will need two or three meetings together the way we did with Vocabulary and Quality so successfully, what a year ago.

I think if we could identify what's most critical and have really, really clear tasks. One of the things you see with the Workgroup is if you say we need to answer these four important questions at the next meeting everybody's there. And if it's a more diffuse task than that, very few people are there.

So, I don't think we know how fast we can go, but I think to your...you know, Doug if we kind of prioritize it, make it as clear as it can possibly be and tee it up so that all the Workgroups have to do is bring their expertise and address them. I think we...I don't think we know if this is realistic or not. I think we might be able to exceed it.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Yeah and I think that there needs to be this iteration where we do a rapid sort of triage, if you will, figure out what's the next thing that we need to do, do that again and this an effort to just sort of start that conversation.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great. Doug and team you could commit to that?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

I'm sorry?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

ONC commit to working with the Workgroup Chairs to do that triage comparity.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Yeah, I mean, we may want to have a couple of Workgroup Chair meetings to just sort of figure out the distribution, what would be the low hanging fruit, you know, so we want to be supportive of trying to get this work done and working with the committee to make that happen and you guys need to tell us, this is outside the scope of what we need, maybe we need some more folks to come into the Workgroup with specialized expertise, maybe we need some temporary members to help us with some particular areas.

There's a whole host of things that we can do with this, it's just a matter of, I think, starting that conversation and creating that iterative process as opposed to here's the charge, let's not hear from you for 6 months, you know, we want to have that kind of thing.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, terrific conversation on this and I realize these baskets are not going to be perfect, probably some analogy or metaphor for the work ahead in terms of parsing activity, but let's move from the committee to crosscutting issues and Dixie why don't you start?

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

Yeah, as I look at this list and thinking in terms of the work that the Nationwide Health Information Network Power Team did regarding the maturity of standards, I can envision a number of standards recommendations popping out the end of the pipe and then we have to go back and having to assess their maturity and whether they're ready to move on, whether they need more investment from ONC, I think that we should somehow figure out how all of these groups can consider the metrics that we developed as they're moving forward through this work so that we don't have to then loop back at the end and assess the maturity of the standards that are being recommended.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Amen.

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

So, how are you going to do that Doug?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

We're going to ask Dixie to attend every single call. No, point well taken, maybe what we need to do is that we need to sort of train the trainers, if you will, get some folks together who can understand that and have someone in each of the Workgroups be responsible for that assessment or bringing it back.

I don't think we can rely on the NwHIN Power Team to be responsible for everything. I think we need to educate and get feedback with all of the different groups any maybe there's someone there that just needs to be identified as the liaison or the expert, or the person who can do that.

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

Yeah, that would be easier for us to do.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Yes.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, well let's talk about other crosscutting issues. I'm going to assume these cards are up for crosscutting, I'll come back to the specific issues and we'll start with folks who haven't weighed in yet this morning. So, let's start with Jamie and then Cris Ross.

Jamie Ferguson – Vice President, Fellow - Kaiser Permanente, Institute for Health Policy

Okay, thank you, so this is one of those crosscutting issues, but I have specific example and I think it...it relates back to and I think supports the point that David McCallie made earlier about the standards lifecycle and determining, you know, when do you build on the last thing and when do you jump to the next thing.

So, on page four, number one at the top I noticed that on most of the rows Doug you had...you started the item by saying standards for a particular function or standards to deal with an issue, but on this one you identified improvements to the C-CDA and I have to say I'm personally not yet convinced that improving the C-CDA for all those purposes is exactly the right answer and this maybe exactly a point on which we can devise some process for determining when it's appropriate and within what boundaries is it appropriate to improve the last standard versus jumping to the next standard.

And I think the standards maturity assessment of the NwHIN Power Team is a good tool, an important tool, but certainly not the only tool in making that kind of determination. And I think the work that's going on in FHIR, so I mean, we have HL7 version 2 and version 3 which is CDA and version 4, which is FHIR and, you know, so determining sort of when to make the jump and do we skip version 3 and go from version 2 to version 4, when is it anticipated to be ready and fit for purpose.

I think we don't want...I agree with David's point earlier, we don't want to necessarily always be improving the last thing for the next problem, but I also think we need to spend some time in the Workgroups to talk about common processes and decision criteria for deciding sort of when to

cut off the last standard in order to anticipate, you know, and focus on moving to the next one.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Real quick comment to that Jamie, which is it is absolutely essential that the Implementation Workgroup folks weigh in because to all the comments you guys have made the last thing that we want to create is an overly cumbersome let's say swat a fly with a bulldozer solution, right? If we're just on the cusp of creating the fly swatter than actually our answer to ONC will be, you know, on this one our recommendation is wait 6 months and then we'll achieve what Dixie has articulated as a standard which is much more likely to become mature than one that's going to decline because it will fail under its own weight.

Jamie Ferguson – Vice President, Fellow - Kaiser Permanente, Institute for Health Policy

I think that's a very fair response.

Arien Malec – Vice President – RelayHealth Clinical Solutions

Just as a follow-up to that, can I make a request that at some near term future meeting we get an update on FHIR, potentially an update on CIMI to get a sense for where those two efforts are relative to this timeline.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Already got it on my list.

Arien Malec – Vice President – RelayHealth Clinical Solutions

Great.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, Arien and after Cris Ross we'll come back to you, I assume that was not your question?

Arien Malec – Vice President – RelayHealth Clinical Solutions

No.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

So Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, so this maybe beating this to death, but I want to make sure we have some clarity on it, you know, I understand the conversation most of this has been around what can the Workgroups absorb and what can the committee absorb and I'm sympathetic to the idea that, you know, when you kill the elephant you have to slaughter it, you can't let it lie and we have to take on this body of work, that's an ugly image, but part of what I'm questioning though is I note in the left-hand margin, Doug, I think it really makes sense when you say based on readiness.

And I think one of the issues there is kind of around industry readiness, part of this is what can we all take on, but the other is just how will we systematically understand what the industry can absorb, what things are...I mean, a lot of this stuff makes sense, the order makes imminent sense around how we're sort of expanding the core and refining it and then there's some other stuff later in the year that's maybe some newer kinds of things.

But I think that's one of the things that Liz and I wanted to focus on was to try to get feedback from the industry around, you know, how fast can we go? How deep can we go? And, I think we would take suggestions from anyone on the committee around how we might frame that up. And, I don't know how you think about that Doug, but, you know, sort of how do we match industry pace and industry ability to absorb?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, one of the things that S&I 2.0 is trying to do is a recognition that, you know, initially what we wanted is that when we set up the use cases we want industry to be present, we want the testing folks to be present, we wanted all the folks at the time we set up the use cases so that we develop standards that were kind of aligned with where the industry was. And frankly, the industry didn't show up in most of the initiatives. It became most standards development experts and things like that.

However, as we go into Meaningful Use Stage 2 there is going to be a need to implement this and we need to support the implementers who are out there, most of them are the vendors and the testing communities and so one of the things that we've done in the S&I Framework 2.0 is that we've tried to create sort of two different communities of outreach, one, that is working on use cases and harmonization and the technical infrastructure around standards and the second that really is about supporting the implementation of the standards that are part of Meaningful Use Stage 1 and Stage 2.

What we want to do and it's going to take us some time to turn this ship, but what we really need is we need the implementation folks to drive the standards rather than the other way around and what that means is, is that when you're implementing, when you find that there's a challenge or a problem you feed that back into the standards group and say, listen it's too complicated you've got to make it simpler or you say there's a big gap and we need to get something different here and we need to be able to support it.

And so we're in the process of trying to turn that ship, in large part its if we can focus on the implementation and testing and I wrote it down here, we need an update on the implementation and testing platform which we are in the process of slowly rolling out, we're not making a big bang but there's a bunch of stuff out there that we're trying to do.

Because I need to...I mean, my big fear is that as we come against interoperability challenges we need to triage them, because sometimes it's about improving our testing infrastructure, sometimes it's about making our implementation guides more focused and less optional and sometimes it's about adding features or functions to our standards in such a way that we'll be able to improve them.

And if what we do is we rely on the SDOs to improve interoperability they will always come up with a standard solution. If we rely on the testers they will always come up with a testing solution, you know, so what we have to do is we need to have some way of getting that conversation to happen more broadly and that's what this implementation and testing platform is intended to do, to create forums and discussions that will allow us to triage where we need to solve the problem and have those conversations so that we can direct it.

I think the other thing that I want to say is that when it comes to things like, you know, do we improve our existing standard or do we start with something brand new? This is going to be a scoping issue, because an incremental change to a complex standard maybe less work than a whole hog sort of starting over and I think we need to have that conversation.

What I have heard from this group is that consolidated CDA is not the final state that we'd like to be in, but it's on a path to something different. What is that something different? How do we get to that something different? How do we create structured data capture which has atomic elements that need to be composable and then kind of documents that we're trying to break up into segments because they've got to meet someplace in the middle.

So, we need to have those conversations and I think it's wise to sort of call that out to say, you know, improvements here and I didn't follow my structure that I used for all the other ones, but we have heard that this is not the end and we can talk a bit about FHIR, FHIR is being driven out of HL7 by two people right now and I would be delighted to try to get more, but I need to have a broader base of folks that know about FHIR and can support it and things and until that happens it's really hard for us to say there are two people who know how to do this, we're going to hope that this all works.

So, the thing is we're tracking it, we're trying to figure out the best way to engage, is there a small project that we can do that will pilot this, these are the kinds of conversations that we're having, but we also have to be careful that we don't create churn where what happens is that for 2 years we do the consolidated CDA and for the next 2 years we do something else, and then 2 years after that we do something else.

And the thing is that this is a conversation that we, ONC, need to facilitate in the community because there's a lot of different stakeholders that may have different opinions about that. We just need to have that conversation and I think if we can articulate where we'd like to go, which I parsimony. Parsimony is easy building blocks that are going to create innovation and drive forward quality improvements and patient engagement all those other things. I think we might be able to get to a better place.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, this is hard to imagine a conversation that's more central to actually the overall task in this conversation. I think there's a clarification from Chris Chute. Then we're going to go to Arien Malec and then Dave McCallie and then we'll see if there are any issues on specific items though we have encompassed those in our broader discussion.

I know that the time is 11:15ish and Jodi Daniel started at 11:00, so we'll keep this somewhat focused knowing full well that a number of these conversations will be recapitulated in the first meetings of the Workgroup actually addressing these items. So, Chris you have a clarifying question/comment first?

Christopher G. Chute, MD, MPH, DrPH, FACMI – Professor – Mayo Clinic College of Medicine

Actually it's a segue question because what Doug was describing in terms of these fragmented issues and indeed the overarching coordination of these activities is really the crux of it. Much of what you've described, Doug, and indeed many of these initiatives are at some level bottom up, they focus on specific issues, specific questions, specific functions, we've looked at query, we've looked at API, we've looked at various types of purpose specific standards.

The obvious question, for many of us, is how are we coordinating the top down? How are we looking at the overarching architecture and coordination and integration of these things, and for that matter the strategic longitudinal planning that you just alluded to where, you know, you don't want to do 2 years of this and then 2 years of that, there needs to be a cohesive and reasonably coherent top down view yet I'm hard pressed to find it anywhere in the HIT Standards activities that we've engaged in historically.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Do you want me to comment on that? I agree. I think part of the challenge that we have is there is a tension between top down and bottom up. I think there is, you know, we've talked about it before in this forum is if you take a look at Health IT it's an ultra large scale system, which implies that this isn't about architecture it's about city planning. So, what is it about city planning that we need to do?

You know, so architecture is you build a building and you know where all the egress routes are and you know how big the buildings are supposed to be and you can create blue prints and it all sort of works, but no one would ever consider creating a city using a set of blueprints like that and so what we have to do is if we think it's going to be heterogeneous and we want all the pieces to fit together the question is, is where do we build the roads? Where do we put in the electrical systems? How do we get water and sewerage to all the places? How do we create zoning laws, if you will, about how things should work together so that one person doesn't build a ginormous building that over shadows all the other buildings?

How do we get building codes that say when you build a building here's how you make it safe and here's how you make sure that it's going to fit with all the other buildings, it's a challenge and I think there is this tension. Should we start at kind of an enterprise architect view of how we're going to get all these HIT systems to work together or do we have to fit some place in the middle about, if this is a heterogeneous environment that's more about city planning than it is about building a building what does that look like? And I think that's the challenge that we have.

And I think folks around this table can really help us guide a path, maybe there are specific kinds of high-level architecture, which is to say the streets all go on a grid and that we make sure that everybody rides on the right side of the road and maybe there are things that we can put out there that say here's how you put together the various pieces without necessarily specifying that every building in the whole place has to have exactly a 10 foot or an 8 foot, or a 16 foot ceiling for example, because there may be different purposes for which you'd like to build a concert hall versus a chamber orchestra area or just a practice room for the instruments.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

This is an important sort of philosophical discussion and, you know, in a sense it's not answerable, but I think the metaphor of city planning is very apropos in the sense that you have enough specification that you end up with something that's coherent yet not so over specified that either you can only build things that are absolutely identical or nothing at all.

And so, let's put that piece apart, what is the kernel crisp that I want to take out of this, is how do we have enough direction that the work that we do is coordinated and in that regard. I think, let's use this framework and diving down further into that are there...what are the internal inconsistencies or consistencies that allow us to have that city plan as opposed to a building architecture.

The other, just for the sake of stating the obvious, is that, you know, it's also an open democratic and politic process part of the reason this is organized as a FACA committee, a Federal Advisory Committee, is to seek public input into that discussion about the type of city in which we wish to live and that is that piece.

So, let's cone down and we're going to take it back to the crosscutting pieces seeing what's consistent or inconsistent with what would emerge as a city plan understanding the political reality that if it's over specified it's both impractical at every dimension one can imagine and if not specified enough we don't have the interoperability that we seek. But great insert there Chris. And Arien and Dave McCallie and let's see if we can't reserve some time for Jodi in the next section.

Arien Malec – Vice President – RelayHealth Clinical Solutions

Yeah, Chris tee'd up my comment perfectly and I've said this before and I'll say it again. When I look at the Meaningful Use Stage 3 work plan from the Policy Committee my biggest critique of it was that it didn't outline an end, it had a bunch of stuff. And when I look at this work plan it's a bunch of stuff but I can actually...I can back map to the end. What I can't do is map that end to the Policy Committee's end in this notion of working from the end in mind and working with a defined timeline.

And I think a lot of us have circled around this issue, but we need...we don't need standards, because standards and \$3.00 will buy you a cup of coffee these days, what we need is the broad and universal adoption of capabilities based on standards and we need a good articulation of what that broad and universally adopted set of capabilities are.

We need an articulation of the timeframe for that broad and universally adopted set of capabilities is and then we need to map to where do we have gaps in existing standards. Where do we have gaps in existing standard programs? And how do we advance the work towards that end in mind? And I worry, I actually...I'm terribly worried right now about the Meaningful Use 3 timeline because I feel like there's a note of irreality in terms of the timelines that we're marching towards and the work that's going on, on the ground.

And until we do that work and harmonize between ourselves and the Policy Committee and establish that, and it isn't a top down plan in the sense of a set of marching orders for individual soldiers it is a classic strategy plan that says, we need to take that hill and taking that hill is part of this broader set of objectives, that's the lens that we're missing and I'll follow or conclude the remarks by saying I'm happy to volunteer in whatever work's necessary, because this is something I'm, as I think people have seen me make the same comment over and over again, very passionate about and consistent about hopefully. So, happy to volunteer to do whatever work is necessary to remediate that.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Thanks, Arien and John Halamka?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Farzad has left, but I wonder Doug, I mean Arien's made this comment, I actually have heard this theme from many others, if we are going to ensure that the standards are going to be forward thinking, mature enough and right might the Standards Committee want to go back to ONC and say, you know, the current timeline for an NPRM actually should be stretched out a little bit so we actually can do some more foundational work.

Actually, you used the word foundation as well. I mean, of course we are always eager to put in as much time as you need, but there's a certain alignment of reality when we say, you know, FY13 can you just defer the NPRM until FY14 so that we have the luxury of time to lay the foundation correctly or some recommendation like that.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

I'd just note that, you know, we do interact with the Policy Committee and with ONC and the conversation is where do we believe we have standards, where do we have aspirations and what's the timeline for fulfilling some of those aspirations and just, you know, in more broader terms I think those dialogues have to be grounded, Arien, quite rightly in the reality of what exists, what can exist and what can exist over what time period and so look forward to those conversations with Doug, Farzad and team.

You know, everyone I think is absolutely correct is that one of my bosses likes to say no matter how well intended 9 ladies can't make a baby in one month and, you know, some projects just can't be parsed into shorter sign segments and certain pre conditions have to exist for the next stage and we get that and so these conversations are ongoing.

So, let's focus on what we can do and how we can go about it understanding full well that the dialogue does have implications for what we can provide and when not only to S&I back to the Policy Committee and to ONC. David McCallie, I believe you're next?

David McCallie, Jr., MD – Vice President – Cerner Corporation

Yeah, just a...I mean, I think this is piling on an being consistent with what's been said, but it strikes me that, you know, when you have a long list of important things or a long list of interesting and challenging things to do it helps to divide them out by what's important and what's urgent and, you know, some of these are really urgent maybe not quite so important, some of them are really important maybe not quite so urgent and there are a few of them that are really important and urgent in particular in the context of existing timelines for Meaningful Use Stage 2 and Stage 3.

So, I think one of the things maybe the Committee Chairs, the Workgroup Chairs can do is categorize these by the ones that we really have an urgent need to solve quickly because it effects the work that's underway now for Stage 2, Stage 3 and then those things which are really interesting problems but maybe aren't so pressing, because some of these are easy and some of them are hard too, there's another access.

And the other comment I wanted to make is, you know, you brought up punctuated equilibrium. I mean, I think standards should be comfortable with that model that there comes a point where you stop and old standard and start a new one because it's time to jump and that gradual evolution is not a requirement for a standard. Standards that get evolved too far will get so crusty they don't work.

So, I don't think there's a particular problem, healthcare is filled with old standards which no one develops any more but which solve current problems fairly well, the billing standards, the HL7 version 2 standards. It may be time to move on to a new family for some of these domains.

The ones that aren't so urgent and that we have time to work on them like for example, opening a window into EHRs for universal query language. I mean, that's a really interesting problem but I don't sense it as being a very urgent problem and it's a complicated one that doesn't have a whole lot of good choices available.

There's work underway with the SHARP Grant obviously in Boston that's exploring one approach let that play out over the next 2 years of the Grant's life and see which vendors adopt it for example, maybe that one where we just wait on that for a while. So, anyway, I'll stop there. Thanks.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay. I have a recommendation, it is approaching 11:30. Jodi Daniel's team, many of the members are from other agencies they have to be here this morning. John has volunteered that his comments on the exchange hearing report out can be shortened a bit. Doug will be here for the ONC updates and we can also take some additional questions on specific standards, but I think we've had a very robust and thoughtful discussion about the broader interrelationships, the overall architecture of the city and our working approach and I think that was absolutely terrific, energizing.

I think all of us feel the weight of the work ahead. Arien, I think you remind us, quite rightly, that that weight is amplified by an appearance of certain mile makers and simply note that those mile markers are informed by the realities of what exists and that doesn't diminish the rapidity with which we'll try to address providing standards for the aspirations of the next stages of Meaningful Use, but it will be tempered by the reality of what exists, what can exist and what is more aspirational.

So, great discussion, appreciate everyone's engagement in that, certainly Doug, ONC team brilliant work as always and we in turn will try to do our best and let me thank all the members of the Workgroups for your volunteering.

Walter, as you pointed out, this is not just a quarterly event, it can take a lot of work in between and I think Doug identified that the situation may necessitate the Workgroup's adding some ad hoc members periodically to address particular areas. So, at this point we're going to turn to Jodi Daniel for a summary of the public responses to the HIT Policy Committee Request for Comment and here we'll focus out I believe on Meaningful Use Stage 3. And Jodi, you're going to present from there?

Jodi Daniel, J.D., MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

I'm going to stay here. I have Michelle is going to be sort of doing most of the heavy lifting and I'm just going to kind of kick it off. We've got Michelle Nelson, Kory Mertz, Jesse James and Will Phelps who will be going through the details. I just wanted to kind of kick it off and open it up for folks and give some of the basic information. Is there a slide? Ah, here we go, okay, great.

So, just by way of background ONC posted the Request for Comment on our website on November 16th we had a 60 day comment period which closed on January 14th. Very quickly in time for the February 6th HIT IT Policy Committee we went through all of the comments and I will assure you that every single comment was reviewed in detail by our team of staff who worked nonstop and very intensely to go through the comments, do a review, summarize them and develop some of the high-level feedback of the public comments as well as some of the details.

Our expectation is that we wanted to give both the Policy Committee and Standards Committee a brief overview of everything that we heard in the comments and that we intend to work more closely with the Workgroups starting with the Policy Committee to go through the comments and consider how to shape recommendations to ONC for Meaningful Use Stage 3.

So, this is our first step, it's not our last step. We will be doing a lot of work behind the scenes working with all of the committees as folks are digesting the comments, trying to understand who made what comment and whether or not, you know, how to address some of those comments best.

But, you know, I want to publicly thank all of the hard work of the ONC staff, there are many more than the four that you see here who worked on reviewing all these comments and really appreciate the time and energy that went into trying to do this so quickly with such a fast turnaround and to give a voice to all of that public comment that we heard.

So, on February 6th we did give a high-level review on the comments and we did get feedback from the Health IT Standards Committee from John Halamka, so thank you very much, and we will be, as I said following up with the Workgroups to do a deeper dive into the public comments.

So, we're going to have Michelle Nelson kickoff the discussion and talk about some of the themes, comments and some of the specifics that we heard and then pass it onto the others on specific areas of information exchange, quality and privacy and security. So, Michelle, take it away.

Michelle Consolazio Nelson – Office of the National Coordinator

I'm going to start by walking through some overarching comments that we received and then a few Meaningful Use items. A lesson learned from when we presented to the Policy Committee, from the Meaningful Use perspective there were 46 objectives proposed from the Meaningful Use Workgroup and it's just too much to go through in detail here. We can certainly share those slides with the high-level summary, but it's just too much for this group. Just, also once we go through I'll also provide some next steps for the Meaningful Use Workgroup based upon the Request for Comment feedback that we received.

I just want to reiterate what Jodi said and thank the public, we received 606 comments, very thorough responses, people took a lot of time to provide their feedback and I just want to take this opportunity to thank the public for their feedback. And also reiterate, I want to thank my ONC colleagues for all their help in preparing the summaries that we had put together.

So, we heard from a lot of different types of organizations. I'm not going to take the time to read this list to you but you can see from the vast array of organizations and a lot of good different perspectives that we heard from.

Some overarching themes that we heard, overall people, the commenters were hoping that there might have been a greater focus on outcomes in Stage 3 a comment that you'll hear throughout and we'll kind of return back to when I talk about next steps for the Meaningful Use Workgroup.

There also was a lot of prescription that people felt had to be left a little more flexibility. There could have been more room for innovation, a lot of focus on functional objectives and again, very prescriptive. So there also were some concerns about timing, things that we kind of heard a little bit here earlier today, that the public was hoping to have experience from Stage 2 before thinking about increasing thresholds, whether an item should be a menu item or a core or, you know, how the objectives should be increased for Stage 3 or where it should go for Stage 3.

Something that we definitely heard from all the great work that the Standards Committee put into providing us feedback was that a lot of the standards necessary to support the recommendations are not necessarily available today and may not be there by the timeline that we have put in place for Stage 3.

Another theme that we heard is to really focus on interoperability and identify the limitations that are there and also there's been a great deal of concern from commenters about the pressure that is on providers today with all of the competing programs that people are participating in, there needs to be a greater focus on measure alignment, quality improvement and the infrastructure and standards to get us there. Also, ICD-10 is another thing that many are concerned about.

There also were comments about ensuring patient safety, remains a high priority and synchronizing that with Meaningful Use. We'll kind of talk about that a little bit later today. And there also were comments that not everything needs to happen within the EHR that there are other technologies available that we need to be leveraging.

And finally, a lot of the comments that you'll hear from my colleagues as well, we had put in items that were not necessarily use cases but were just certification criteria only items. Those items caused a lot of confusion for the public, they weren't quite sure what they were, some missed that they weren't actually use cases we were just asking for the standards to be available to make things happen. So, you'll hear that when you hear the feedback from my other colleagues.

So, as I mentioned, I am not going to go through all of the Meaningful Use measures and objectives, there are 46 of them, much too much to cover here. There is one objective that I do want to take the time walk through because I think it leads into where the Meaningful Use Workgroup is going and some of what Jesse will speak to when he talks about quality improvement.

I do want to talk about that CDS objectives, it was also brought up here today in regards to Health eDecisions work. So, in the CDS objective that we had proposed there was a lot that we put in there. We were trying to do a great deal with that, which I think caused confusion and lesson learned, there probably was too much in one objective.

So, things that we heard about the...we were pushing to increase from 5 interventions to 15. So some of the concerns were heard about that was that there was alert fatigue out there and there's lack of CDS interventions available for specialists and a note that passive CDS is acceptable and what constitutes a Meaningful Use intervention and how do you measure interventions? And, also people were concerned about if there had to be 15 interventions did that have to be at the provider level or the group or practice level?

And some suggestions that came out of the recommendations were to focus on outcomes and let providers pick the CDS interventions that are appropriate to improve their quality of care. To remove drug-drug interactions, because that is where the alert fatigue comes in and there is little support for...so we had also recommended that you be able to track and see how a provider responded to a CDS intervention. And the comments that we received was that there was very little support to do something like that.

And overall there was broad support for the ability to have certification criteria to be able to consume a CDS intervention, you know, similar to this Health eDecisions work that's underway, but there were concerns about the ability to customize and accommodate at a practice level. So that's just a high-level review of just the CDS objective, but I did want to go through that just as we talk about quality improvement with Jesse and I loop back to where the Meaningful Use Workgroup is going.

So, we also had a few high-level Meaningful Use questions that we asked. There are just a few of those I want to go over here because they relate to some of the other work that Jodi actually will speak to later today. So, one of the questions we asked is what is the best balance between the ease of clinical documentation and the ease of practice management efficiency? We had a clinical documentation hearing last week, Jodi will give an update on that later on today.

But, I did want to mention some of the feedback that we heard was that most were in favor of improvements in overall usability that would be able to find a balance between practice management and clinical documentation. Another question that we asked that I just wanted to briefly review was whether a safety risk assessment should be included within part of Meaningful Use.

Overall commenters did not agree with including this in Meaningful Use and again the Certification and Adoption Workgroup which is part of the Policy Committee did some work and made some recommendations to the Health IT Policy Committee which Jodi will review later today. And with that I'm going to turn it over to Kory Mertz who is going to review, there were three information exchange items, so he'll go through those.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator

Thanks, Michelle. Just going to go through these here quickly here for you guys. The IE Workgroup put three recommendations forward to the Policy Committee that we received feedback on. The first one was around querying for patient records. We received 102 comments on this objective many of which supported inclusion in Stage 3. However, there was confusion I think from a lot of folks as to really what this objective meant. I think a lot of folks thought it meant it was going to require them to participate in an HIE or HIO that was operational in their region, whereas, you know, that wasn't necessarily the sole way the IE Workgroup was thinking about this objective being able to be fulfilled.

There were a number of comments around the need to think about additional or the implications of privacy and security around this objective and some additional areas that need to be looked at, for instance how is consent management going to be done, what are the requirements in the authorization form? The Privacy and Security Tiger Team of the HIT Policy Committee is currently looking at this. So, they're going to be taking a deep dive around this sort of approach.

A number of commenters requested that they thought this objective around querying for patient records should be able to be supported through an HIE or HIO type entity so that providers could, you know, use that as a way to meet this objective and so that's kind of a quick high-level on that, you know, we certainly have a lot more detail and happy to answer any questions folks have.

The two other areas, there were two specific questions we asked around this, one was around what the measure should be for this objective. Should it either be percentage-based or a just a raw number of patients and the commenters, the majority of commenters thought a percentage base would be the best. They also requested additional detail in how the measure would be calculated. So, for instance if a query failed how would that be...how would that fit into the measure?

And then the second question the Workgroup asked was around patient matching and how the best way to do that through this objective would be, you know, commenters were a little all over the place on this one. There were some who thought there needed to be...there was a lot of support for more explicit patient matching standards and some requested the establishment of a national patient ID.

So, moving on, IE Workgroup 102 is certification criteria only for querying a provider directory and as Michelle noted in her comments this was one that definitely led to some confusion amongst the public. A lot of people seemed to think this was...you know, it was also an objective and requiring the actual use, so there were a lot of questions of, you know, is there, are there provider directories out there that we're going to be able to query? What are these? So, you know, I think a lot of the comments were fed through that.

The other interesting dichotomy here was, you know, the most commenters didn't feel the standard readiness was there for this to be in place for Stage 3, but on the other side of that coin, you know, it was about split evenly as to whether this criterion needed to be in Stage 3, so it's kind of an interesting dichotomy. People didn't feel like the standards were ready but it was, you know, kind of an even split on whether we needed this for Stage 3.

Moving onto 103 this is focused on data portability. We got 56 comments on this and, you know, the majority of commenters really felt this was an important area and wanted to see further progress around this, you know, one of the areas specifically called out in this question was around what data elements need to be included to really help make this even more useful and, you know, the majority or kind of the most common responses seemed to be focused on kind of two areas.

One, wanting to make sure data elements should be included in the data portability criteria for anything they would need to calculate quality measures, historical quality measures moving forward when they switch vendors and then the second area was recommending new data elements that are included in Stage 3 be added to this criteria as well.

And moving onto the last one, one of the overall criteria similar to...thank you, was MU05 and this question is really focused on innovation in health information technology and how EHRs are going to interact with other technology within healthcare. So, you know, getting back to some of the conversations earlier today around, you know, do we need to be looking at APIs or other ways for EHRs to interact with devices?

So, we received 78 comments on this, you know, I think a couple of key themes that we saw in this was, you know, I think there was support for the idea of finding another way for EHRs to interact with other technologies, you know, I think people see that we're putting a lot of things into EHRs but there's roles that the EHR technology isn't best meant to play. So, I think there was support for APIs or other ways for EHRs to be able to interact send and receive information from those systems.

There were differing views on whether kind of the existing standards were going to be the best way to do this or not. So, that is a quick overview of those four items and I'll pass it over to Jesse.

Jesse C. James, MD, MBA – Office of the National Coordinator

Thanks. So, the Quality Measures Workgroup in the RFC wanted to think about...to focus our attention on how Stage 3 is used to drive improvement and we thought first about Stage 1 where the goal is adoption, in Stage 2 the goal is to measure in a standardized manner and we'd like to be confident that as we move forward into Stage 3 we are using our measures for improvement and we see improvement as not only being calculating, capturing and calculating measures, but also using that data for CDS as well.

So, we started with a framework that first asked questions about the purpose of the program of CQMs in particular and then asked questions about the measures. How we make the measures? Which measures we choose? But also how we leverage the measures for improvement and in this brief cursory review of our comments I have chosen sections of the RFC that were important from the standards point-of-view. So, I'll speak briefly on the innovation track that we proposed in the RFC and on the population management tools or population management dashboards.

And start with an overview of the types of responses we've got or for each group of questions we had a range in the number of responses from roughly about 40 to 50 responses per question. There were 30 questions and they were split up as I previously described.

We begin with a section on the purpose of our program and that being essentially to drive improvement and to use measures that are useful for clinicians and we also asked how do we stay patient centered and how do we receive a broad variety of stakeholder comments, in particular we heard, and this was the theme throughout the comments that we should keep our ear to patients and do so in ways that allow them to engage with us including webinars but also social media and open for or wiki's for input at the measures level both for patients and for vendors and clinicians as well. There were 56 comments in this section and there were a variety of media and a variety of avenues that commenters suggested that we use.

The next section of our RFC asked what types of measures should we use and the age old battle between process and outcomes as previously described. We asked the question should we be outcomes focused or process focused? Should we use suites of bulk and the majority of commenters actually supported using suites or bundles of measures that both have an outcome and where the processes have some correlation with performance and then outcome, especially the provider groups and they make the good point that if you're not performing well on the outcome it's useful to have information about your processes so that you can improve them.

And we asked about de novo or legacy measures, de novo measures being measures that were specified especially for EHRs versus the retooled or legacy measures for measures that were paper extracted or claims-based before and we got strong enthusiastic support for using more de novo measures going forward.

We also asked questions and proposed that we consider an innovation track for CQM development and we proposed that imagine a track where perhaps any provider with certain constraints could build their own measures that were especially meaningful to his or her own practice and that those measures might count towards attestation for Meaningful Use requirements.

And we asked what constraints in particular should be in place if we chose the innovation track as part of Meaningful Use. We had lots of interest in this line of questions and there was strong support for an innovation track and the commenters, the most frequently themed comment was that this is the type of thing we should be doing that this would drive improvement and that clinicians, especially large IDNs are already moving in this direction, are creating their own measures and they would really like to see those measures be a part of Meaningful Use.

There were some reservations about allowing innovation in a way that did not meet with the goals of the nation and there were a few commenters that did not support an innovation track at all. There was one in particular that used the words experimentation is not appropriate within this regulatory environment.

Then our next question was if we do choose an innovation track how conservative or how radical should we be in our approach? One approach might be to entirely democratize the process so that any provider could create any measure within reason. Another might be to have an application process that's similar to an NQF endorsement where you can submit a measure to CMS in that manner. We got strong support for, well stronger support for the alternative approach where we maximize flexibility and would allow any providers themselves to build their own measures.

And then we asked the question, well what constraints, what standards should be in place if we do allow providers to build their own measures and this again went to that tension between innovation but also building measures that are both innovative but are comparable and thus stronger support was for constraining to standards that are currently in place as opposed to minimizing the standards.

And finally we asked questions about the usefulness and the business case, and feasibility of Health IT enabled population management platforms or patient management dashboards and there was strong support for movement in this direction. And also, the expectation that moving in this direction would enable the type of work that ACOs and patient centered medical homes have already been starting.

So, just in review, some of the themes that recurred throughout the comments were that we should be sure that we listen more, that we continue to talk but keep an ear not only to patients but also to the societies that we make measures anew that really leverage the capabilities of the technology that we both liberate the data and the providers and that we focus our attention on the NQF domains, care coordination, patient engagement and safety. Thanks.

Will Phelps – Office of the National Coordinator

I think it's still early enough for me to say good morning. I want to talk to you about privacy and security a topic area that I know is very near and dear to many of you. Here, let's see the first question, how can HITPC's recommendations be reconciled with the National Strategy for Trusted Identities in Cyberspace approach to identification which strongly encourages the reuse of a third-party credentials? We received 41 comments, comments included both those in favor and against recurring identity proofing and multifactor authentication in MU Stage 3.

Among those in favor many feel strongly that identity proofing and multifactor authentication should be required, several want existing standards to be evaluated, some believe the NSTIC model can be adopted in healthcare. Among those against, some believe the deadline to meet the MU Stage 3 timeline is a little unrealistic and others say this would increase burden and cost especially on small providers.

Question number two, how would ONC test the HITPC's recommendation for two factor authentication in the certification criteria? We received 26 comments some examples of a specific testing approaches appear in the slide, I won't read them out, some suggest basing test procedures upon existing standards such as the DEA Interim Final Rule, IFR, NIST 800-63, FIPS 201 and HSPD-12.

Question number three, should ONC permit certification of an EHR as standalone or an EHR along with a third-party authentication service provider. We received 30 comments. Regarding certification of authentication services for EHRs most commenters support one of the three types, certification as part of an EHR, certification independent from the EHR and certification for both models. Alternative approaches were suggested as well such as leveraging methods from other industries like the payment card industry or PCI.

Number four, what if any security risks or HIPAA security rule provisions should be subject to Meaningful Use attestation in Stage 3? We received 46 comments. Comments were for and against requiring attestation for workforce security training, those in favor commented on areas of emphasis which are listed in the slides such as access controls, audits, data integrity and encryption to name a few. Those against say that attestation is a burden or duplicative of requirements already included in the HIPAA security rule.

Number five, is it feasible to certify the compliance of EHRs based on the prescribed standard. We received 30 comments, the majority say that it's feasible to certify compliance of EHRs based on the ASTM standard for audit logs. Some question whether a standard is necessary because the final rule for accounting of disclosures is not yet released and others note that audit logs and accounting of disclosures are inappropriately combined. Accounting of disclosure information seems to be a subset of audit log information.

Number six, is it appropriate to require attestation by Meaningful Users as such logs are created and maintained for a specific period time? We received 37 comments. A majority suggest attestation should not be addressed until the accounting of disclosures rule is finalized. Many commenters agree with adding an attestation requirement for audit log creation and maintenance, those who do not agree with an audit log attestation requirement tend to view audit log as a technical function and view attestation as an administrative burden as well.

Number seven, is there a requirement for a standard format for the log files of EHRs to support analysis of access to health information, access multiple EHRs or other clinical systems in the healthcare enterprise? We received 32 comments in response to this question. Most commenters say that there is no dominate or mature standard currently available. A majority support the concept of a standard format for EHR log files.

Two standards that were suggested are the ATNA standards and use of the ASTM-E E-2147-01 standards. Some commenters were neutral suggesting further study and evaluation of the government's role in this area and some commenters disagree with the need for a standard because it's a burden and unlikely to improve security.

Number eight, are there any specifications for audit log file formats that are currently in widespread use to support such applications? We received 37 comments. Many commenters suggest specifications to consider but none of these are in widespread use. Some comments oppose the addition of any new Meaningful Use requirements based on the proposed accounting of disclosures rule.

Okay, last one I believe, some federal and state health information privacy and confidentiality laws including, but not limited to, 42 CRF Part 2 for substance abuse, establish detailed requirements for obtaining patient consent for sharing certain sensitive health information including restricting the recipients further disclosure of such information.

There were three questions were put forth by the Policy Committee to address those. The first one...in total we received 74 comments across the three questions. Question one, how can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange?

Most commenters referenced metadata tagging and also data segmentation as approaches for managing patient consent and methods for data segmentation include data segmentation for privacy initiatives, what the VA and SAMHSA is doing, and also SATVA. Some commenters say that there is nothing in the marketplace that offers this capability currently.

Question two, how can MU help improve the capacity of EHR infrastructure to record consent, limit the disclosure of this information to those providers and organizations specified on the consent form, manage a consent expiration and consent revocation and communicate the limitations on the use of restrictions on redisclosure to receiving providers.

Suggestions from commenters included creating and adopting standards for the EHR infrastructure in standardized fields for specifically protecting certain health information requiring certified EHRs to manage patient consent and control redisclosure.

Question number three, are there existing standards such as those identified by the data segmentation for privacy initiative implementation guide that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs?

Many commenters referenced potential standards which are listed in the slides, some reference work already being done by some states and the HIEs, some reference a voluntary universal healthcare identifier as a possible solution and some reference the need to work through conflicting state laws and the importance of patient education...that's all for me.

Michelle Consolazio Nelson – Office of the National Coordinator

So, I'm going to loop back and just provide an update, so when we presented to the Policy Committee on February 6th they had a great deal of robust discussion about what we...the comments we had received, again highlighting some of those overarching themes that we heard that standards aren't available for a lot of the recommendations. We need to learn from the experience from Stage 2 and there needs to be a greater focus on the outcomes. So, based upon those recommendations from the public there was discussion amongst the Policy Committee about what can be done to focus on some of those things that we heard from the public?

So, what they decided was that the Meaningful Use Workgroup met in person on February 14th and they discussed some alternative pathways to start to think about some of the comments that we heard from the public and based upon the discussion during the February 14th in person meeting they came away with two alternative pathways that the Meaningful Use Workgroup is going to be diving deeper on and looking into.

The first is focusing more on outcomes and focusing on performance-based deeming. So, the premise is that you won't be able to achieve good performance if you're not using your EHR effectively and you'll be able to do that if you are able to achieve good outcomes or if you're approving them so that you can then deem perhaps for some of the Meaningful Use objectives. So, perhaps using clinical quality measures to take the place of some of the Meaningful Use objectives, but perhaps still focusing on some areas like patient engagement and interoperability.

The other alternative pathway that is going to be explored is what we're calling clustering or consolidating objectives. So, perhaps there's a way to focus on a higher level objective, be a little bit less prescriptive about it. So, maybe something, you know, if they're using a patient portal then perhaps you don't need the secure messaging and clinical summary objective, there's a way to, you know, bring it up a level and consolidate and subsume some of the objectives that are currently recommended.

Although they're researching these two different pathways...so the Meaningful Use Workgroup has broken into two subgroups, they're going to explore these two options. ONC is going bring some information related to quality measures and how some of the quality measures can align across other programs such as ACOs and patient centered medical homes, other things that providers are thinking about today.

And they're going to bring forth their research within those groups during a March 15th in person meeting. During that meeting they'll discuss, you know, perhaps it's a combination of both those options that they're exploring or maybe, you know, you take pieces and parts from both, but once they have that meeting on March 15th they'll then present their findings during the April 3rd Policy Committee meeting.

And following the Policy Committee meeting, depending upon what pathway is decided on, the Workgroup and it's subgroups will then go back and review all of the summaries from the RFC and, you know, make changes accordingly based upon whatever pathway is chosen. So, with that I will open it up to any questions that anyone might have?

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

First let me thank Michelle Consolazio Nelson, Kory Mertz, Jesse James, Will Phelps and Jodi Daniel, terrific overview. I know that represents reams of input or maybe reams as a paper-based metaphor, millions of bits of information that you've received. Jim Walker, let's start with you?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Great work. Thank you. I think these are basically questions basically for Jesse. First, what do we mean and what did the public mean by de novo? Let me give you an example, so let's say there was a quality measure on making sure a patient gets an aspirin when they have an acute heart attack, if you said, okay, we're going to start over from the beginning and create a measure related to that topic that's appropriate for electronic EHR use, is that de novo or is that complete retooling?

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, I would consider that de novo would be retooling if you chose a paper measure that you used entirely as your template to create that measure in the EHR.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Okay, so, I'm going to propose that de novo is confusing language for that. I would say that's not...de novo would be now we're going to have one on bunions. I just think that the conversation cannot...and I would propose that if you did a study, which wouldn't be very hard to do with the public commenters, you would find that their understanding of de novo was not at all crisp or consistent, so that's just a comment.

And this is also a comment, on slide 8 of, no slide 3 of you're...well, I think it was slide 8, where we have two choices constrain to existing standards and tools or have no constraints. It seems to me that there is a useful middle possibility there that would say, if we've decided that it's affordable and rational to have sort of roughly anybody create CQMs you could still have a set of constraints and you could say they have to publish the strength of evidence on which their measure is based and the literature. You could say...

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

When you say strength of evidence are you referring to the recommendation behind the measure or the validation and the reliability of the measure itself?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Yeah, the idea that the measure should be evidence-based and so they should just point to the evidence and there's a standard way of measuring...of expressing strength of evidence.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

And the second part of the question was also the reliability and validity of the measure itself, the testing of the measure not just is it a good recommendation but is the question that's generated from that good evidence-based recommendation also been validated.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

Yeah.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

I want to understand where your comment is coming from.

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

My comment, at first I think yours is a good one, but what I was talking about is just report the evidence on which the measure is based. Second, just report the size of the population to which this measure is relevant. Is it something there's only 250 cases in the United States or is this cardiovascular disease? What is the estimated improvable quality adjusted life years in the population if this were done well? And what is the cost per QALY, and again just report those for transparency. And then the third would be...well the improvement opportunity, what is the national baseline performance?

So, all this would do was make it so that whomever could not create a measure...well, would be embarrassed to create a measure that effected only a tiny population and had only minimal possible improvements and was incredibly expensive per quality adjusted life year achieved. So, I think that would not be too burdensome, would sort of enable them a central agency to look at those sort of custom-made ones and say "wow we missed an opportunity on this one" whereas this one should be embarrassed out of existence.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, let me just take a piece of that off your plate and Jim it sounds like some of that are our comments to the Policy Committee in terms of recommendations in terms of quality measures. By the way, just as a recovering health services researchers what you're articulating in part is numbers needed to treat in terms of a construct that would help determine the utility of a particular measure, but I would align with those questions about what makes a good measure both the recommendation behind the measure and the measure itself. But we should take some of the burden of communicating that to the Policy Committee. Let's go around, we've got about 10 minutes left in this section.

Jesse C. James, MD, MBA – Office of the National Coordinator

If I can respond to Jim's earlier point about the difference between de novo and retooled. So, it's from a measure developer stand-point by reading the comments it was clear that there was an understanding that de novo measures were measures and we described that in the RFC that de novo measures referred to measures that were made specifically for use in the EHR but not necessarily where measures that were made a new that hadn't been previously used in any platform.

So, from the descriptions that we received from both the providers, who described measures that they used and measure developers it was clear that there's an understanding that there is a difference, there is more difficulty and there is less confidence in the results from measures when they're retooled or re-engineered as opposed to measures that were designed for use in EHRs.

And to the second comment about what information might be attached to the measures that were submitted to the innovation track there was a section of questions, nearly I think it's 8 questions, one of the questions asked in particular what information should be attached to an application for CQM and in this forum we decided to minimize the amount of information that we put there. But there were a number of commenters that made a similar description of the information that should go along.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

I want to do three things, obviously engage in discussion around this, this is a very broad deep topic and so we're not going to be able to go through all the points, so I think there are some supervening, so that's point one. Point two is Arien has put forward a comment that I'd like to be sure we sort of close on. So, I'm going to ask that the next three comments be very, very brief and the third is that part of this process is to honor the public input and at 12:15 we will stop to gain public input.

So, we'll just go right down with the request that these be very brief, because I think, Arien, I think you have a concept that unifies both the first and second presentation. So, Walter, Floyd and Leslie Kelly Hall will come with some very, very pithy...okay, Walter you're up.

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

Okay, very brief, my question is much more high level, it's really the sequence of steps that are going to happen later this year. So, I understand that the Policy Committee is going to be getting these and reviewing it and managing it and, you know, coming up with a final set of recommendations and what's the timeframe for those to come out back to ONC as a, you know, this is the final set of recommendations for Meaningful Use Stage 3?

And, then what's the timeframe that you see for, you know, releasing basically the NPRM or not you necessarily but CMS I suppose? And then, the parallel ONC NPRM for standards and certification, so what are sort of the big two timelines in terms of the milestones for this? Maybe Jodi?

Jodi Daniel, J.D., MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

So, this is Jodi Daniel, I'll take this one. We're still working that out. You heard Farzad's comments this morning about trying to focus on implementation and hearing some of the concerns about timing and kind of folks being really focused on implementation and making interoperability and exchange work, and wanting to be respectful of sort of the need to do that as opposed to pushing really fast on the next stage while people are thinking about other things. So, great question, I don't have an answer. I don't have the dates set at this point. But the expectation is that we may not push quite as hard and fast on the Policy Committee at this point in time and we are looking into how we can schedule this.

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

Thanks.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Thanks, so my comment and I'll ask Jesse to comment on this. I think ONC has done tremendous work in January pulling the quality community together to try to improve the infrastructure and the process of developing measures and perhaps making it more democratic for innovative measures to come in. Is there a...one of the things that would potentially help is expanding the definition of a good measure by adding to it NQF already has this criteria, qualities and cost, I mean, that's not in there today other things are and I think they're well defined, but will you be presenting the follow-up of the work done in January to this committee to see how that effects standards and what might need to be done?

Jesse C. James, MD, MBA – Office of the National Coordinator

We'll have members of our team to present, I'm assuming you're referring to the Kaizen that was held at ONC for a week in January where we mapped out the process from a concept in a developer, clinician or stakeholder's mind to a fully specified ECQM release post the final rule with value sets and logic attached. So, there was an update to the Policy Committee and I imagine there will be an update to the Standards Committee. I'm not sure exactly where that will fit into the agenda.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

I just brought it up because I thought it was important for people here if they didn't know about that to understand that there is work going on it's not just the same infrastructure that was, it's moving.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

That ties back with Jim Walker's point as well. So, I do agree that you can transmit that back as we transmit to the Policy Committee that would be great. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President – Healthwise

Just really quickly, thank you for all the great work and Michelle, I think that when we met in the Meaningful Use Workgroup and talked about the deeming and the consolidation I think there is huge momentum there and I would offer that we could inform that process by saying what compatible standards are in each of these areas, because we could deem something being done on a very grand scale if a particular standard has been adopted and that standard is applied to many other of the criteria along with a consolidation. So, we don't have the information I think it would be important.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, I take that as a "to do." Great, okay and then Arien Malec has a bit of a unifying suggestion that, why don't you articulate that Arien?

Arien Malec – Vice President – RelayHealth Clinical Solutions

Thank you, so my proposal is that the HITPC and the Standards Committee jointly collaborate on a strategic plan and the notion is that strategic plan should outline what are the broad capabilities that need to be nationally available in order to meet national priorities and that's really the top level of that strategic plan.

And then based on those markers of broadly adopted capabilities backwards plan to the programmatic alignment so in some cases for example we're already seeing that healthcare organizations are reporting this to NCQA for NCQA endorsed measures for PCMH and this one for Meaningful Use, and this one for CMS, we need to bring those stakeholders together.

And then backwards plan the timeline that includes stakeholder coordination, that includes standards development, technology development and adoption so that we have a well-defined roadmap, if you will, that's really a joint statement between the Policy Committee and the Standards Committee.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

I would ask John to comment, just as sense of the Chairs that this suggestion I think offers, you know, it's a perfect sort of point of segueing both the first presentation, the second presentation into allaying some of the concerns and directing us in shared purpose. John, I know you wanted to comment?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, all today I've been talking about scope and time, and resources. Well, one of the ways to constrain our scope of course is to use Dixie's construct and say, what is mature enough to go forward? What Arien has proposed is actually kind of probably more valuable, which is what actually are the key goals of the Policy Committee and then overlay what is mature and should go forward, because just because a standards is mature doesn't necessarily mean that's it's going to improve quality, safety and efficiency, it's cool, but it may not improve quality, safety and efficiency.

So, what I might suggest is we have our Chairs call and we begin to actually go through the scope of what it is that we reflect and, you know, working with Doug and the Policy Committee is maybe an opportunity for us to say let us go look at our work plan in the context of the Policy Committee's work plan, in the context of what is strategic and the goal overall of Stage 3 to accomplish is it care coordination, population health, care management, you know, what is it at which point we can then constrain our scope and make sure that we're working on from a standards perspective is aligned universally with a single strategy.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Jodi Daniel, do you want to comment?

Jodi Daniel, J.D., MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

I think that that's a great idea and I would just further state that there are maybe cases where a standard is not mature but it's something that's a priority and that may bump it up on the list of things to work on so that, you know, we can get to a point where there is a mature standard.

So, I think it does make sense to look at the priorities from the Policy Committee and ONC which, you know, hopefully, they're aligned, and then try to then look at what's both mature and then what might be possible maybe there are a couple of areas where we do have some standards that maybe less mature but that we know need some work in progress and that are worth spending the time on because of the impact they may have in the policy space. So, just a little caveat on that, but I think it's a great idea.

Arien Malec – Vice President – RelayHealth Clinical Solutions

One of the things I've observed is if there's a clear statement of need and a clear statement of timeline it's actually really easy to get the standard folks and the vendors together to go address the problem. It's when there isn't that it's, well what do I work on, oh, I'm going to work on the thing that I know and I'm interested in.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Leslie Kelly Hall and Dixie Baker, two final words.

Leslie Kelly Hall – Senior Vice President – Healthwise

I would just echo that when we're in a green field like patient engagement the standards will not be mature and so we can't have that be the only factor. So, I echo Jodi's comments and put forward it's actually quite an opportunistic time when there's green field to say, how can we start with a standard and make sure that we're advancing that patient engagement agenda.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Great, thank you, Dixie?

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

First of all I disagree with that, I think there a lot of mature standards that can be to communicate with consumers, but reflecting back on what John said in response to Arien, I totally agree with what Arien suggested and I want to make sure John that you capture the collaboration with the Policy Committee in there not just to look at our work plan, but really there needs to be some back and forth I think there.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great and just to this point, when Doug did what was a very reasonable thing you look at these slides and they say, based on readiness and he did order our work in ways that I thought was very accomplishable but we want to make sure, to Arien's point and to your point, that what we are accomplishing is what actually is going to move the bar to improve health and therefore this collaboration with the Policy Committee probably needs to be a little tighter. In some ways, as was said by Jodi, they should push us harder in areas where standards aren't mature and in other ways we actually might push back on them when we say, well, it's not mature, but it's actually really unlikely to be mature in the next couple of years, so it's a give and take.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Jim Walker, final, final word?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

I just...I guess we're not going to get vote on Arien's proposal, but I want to really reinforced that. I think the Quality Workgroup Vocabulary Workgroup meetings were an example. I know that we got 10 times as much work done as we could have done if we had had separate meetings and sent e-mails back and forth to each other and I think this is a case where we very badly need to sit down and say, this is what we want to accomplish, this is what's feasible well, in light of that then this is what we want to accomplish and we both really know where we're headed.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

You added emphasis to what was going to be my formal words. I really think there is a strong consensus. Any objections to this approach? Then let the record show that there is consensus that this is really a good approach. Jodi, appreciate your leadership on behalf of ONC.

I want to thank you, Jodi Daniel and the team, terrific summary of a lot of information and Arien and all, really terrific conversation. John, appreciate your framing that in practical next steps and Jodi for us to take forward, but obviously consensus on that and a very nice point on which to end this component and move to public comment, and then after that there will be a lunch break. So, let me ask MacKenzie Roberts to go ahead and invite the public in for...I'm sorry MacKenzie Robertson, to invite the public in for any comments.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Sure, operator can you please open the line for public comment and while we're waiting for the lines to be open if there anyone in the room that would like to provide a public comment if you can please come up to the table?

Alan Merritt – Altarum Institute

And if you'd like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

Robin Raiford – Advisory Board Company

Hi, Robin Raiford...

MacKenzie Robertson – Office of the National Coordinator

Sorry, just one minute, and I'd just like to remind all the public commenters both on the phone and in person we will be limiting public comments to 3 minutes, so I will be jumping in at the end of the 3 minutes, and for the people in the room there is a clock on the screen as well, so it will help you gage your comments.

Robin Raiford – Advisory Board Company

Okay, hi, it's Robin Raiford I'm here just a public citizen to make a comment, I see the clock. So, anyway happy to be here, happy to see some faces and to comment kind on what Leslie said about patient engagement to maybe give the suggestion to reach out to the Healthgrades organization where consumers can get in there and rate their organizations, rate their hospitals that they went to and I've recently found out that there is one hospital in the Washington, DC area that was scored patient excellent by the Healthgrades Organization it's in Virginia and there apparently is some process where people can get out there and do that.

You've heard from my comments that last couple of months that I'm still trying to get over the blithering idiot or person with no brain that didn't know to give me high dose steroids for 6 days and stop it for 36 hours, my adrenals didn't like that, so I hope my legs and my strength will come back soon.

But, I would also want to just bring to thought of words that are acceptable to say in a public forum that people that don't have an EHR I think are functioning somewhere between blithering idiot and person with no brain. It is unbelievable to me when I go through the 100+ pages of 3 hospital admissions and 7 rescue squad events the stuff that got made up, left out, assumed and just poor judgment and no medication reconciliation and to realized the strength 45 meetings later and the 45 meetings yet to come to make this right, that you're standing up for somebody's right to be alive, to be able to walk and to stop the medical errors.

And for people that...to give the strength to the ONC that I don't care if you get a 100 page letter from the AHA and the MGMA somebody's making an assumption, people are making good decisions they're without an EHR and having the experience with no EHR and with an EHR I do intend to get with HIMSS and try to write a patient survival book of how to do that and interestingly enough somebody that I just graciously met at the Fairmont who was just all of a sudden in front of my was Gayle King who happens to be Oprah Winfrey's best friend.

So, I do intend to reach out to her to maybe do some story on the consumer and how to survive going to the hospital when there is no EHR and meanwhile I'm going to get a tattoo if there is no EHR just leave me in the street and let me die. Thank you.

MacKenzie Robertson – Office of the National Coordinator

Thank you and we do have another public comment in the room. Sir if you could please identify yourself?

Gary Dickinson – Director, Healthcare Standards - CentriHealth

Yes, this is Gary Dickinson I'm the Director of Healthcare Standards at CentriHealth, I'm not quite sure how to follow that, but I certainly support what Robin is saying. As a concern for all of us, those of us who have been recent patients have similar experiences, so I think that that is very valued and wise words from Robin.

I would like to point out in terms of my comments today that the RFC for Meaningful Use 3 that was published and open for comments up through January seem to focus on a pattern that we're going to proceed in this particular direction regardless and there doesn't seem to be any interest, at least from the way the questions were posed in learning the lessons of Meaningful Use 1.

I realize Meaningful Use 2 is a little bit early to get lessons from but there probably are a few people who could even give us some lessons on Meaningful Use 2 already, but the RFC didn't really open the door to those kinds of issues at least it didn't seem to from my stand-point.

So, as an individual who submitted eight comments on the RFC none of which related to the specific questions, because I felt that the specific questions were out of order, until we address these issues that are being raised by the industry today, read the press, read the IT press, the HIT press you know what those issues are and they're not being addressed by Meaningful Use 3 or the RFC that's being proposed for Meaningful Use 3 and I would say that the key issues are around trust.

And trust and information, that information that we're generating reams and reams of information in the paper world or in the electronic equivalent of paper world and a lot of that information simply can't be trusted, because we don't know where it came from. We don't know who the author was. We don't know the context. We don't know the purpose of capture. We don't know when it was captured. We don't know the context in the context of a sequence of events that might have occurred where this information is just a single data point out of that flow.

So we have some real issues, trust and usability I think need to come very close to the top as we look at this. So, I would argue, as we look at the 27 items that are being proposed for scrutiny of this next year by the Standards Committee that we really focus on the EHR front-end, the interaction with the provider, because perception of success is going to be how well provider believe these systems are supporting their practice and allowing them to engage successfully with patients and manage their operations and their work flow in the most efficacious and efficient manner possible and that's not what we're seeing in these 27 items, only one relates to usability and the rest of them are mostly obscure things that have little to do with the front-end, the physician, the provider interaction with their patient, with the system at their side through that process and I think these are things that need to be addressed as a priority.

MacKenzie Robertson – Office of the National Coordinator

Mr. Dickinson, your 3 minutes are up, thank you.

Gary Dickinson – Director, Healthcare Standards - CentriHealth

Thank you.

MacKenzie Robertson – Office of the National Coordinator

Are there any other public comments on the phone?

Alan Merritt – Altarum Institute

We have no comments at this time.

MacKenzie Robertson – Office of the National Coordinator

And any more public comments in the room? Okay.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, let me thank both of our speakers, our public commenters and wishes for your good health, Robin, are with you and Gary we appreciate the passion you bring and I think to all of us it's just really a very poignant reminder of the importance of the work we do and through that I express my appreciation to each of you as a prospective patient, as a member of a family of prospective patients, a community of prospective patients, this is in the end about very real people and very real social systems as was described and hope you enjoy lunch. Think about these issues. We'll network on some of these issues and we'll reconvene sharply at 1:15 where Dr. Halamka will kick off with a report out from the Health Information Exchange Hearing and we'll move on to ONC updates and any unfinished business of the morning. Thanks all, we're adjourned until 1:15.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, ladies and gentlemen why don't we go ahead and get started. MacKenzie Robertson, let me turn to you for a moment.

MacKenzie Robertson – Office of the National Coordinator

Sure operator can you please open the lines back up?

Operator

All lines are open.

MacKenzie Robertson – Office of the National Coordinator

Thank you and with that I'll turn it back to you Dr. Perlin.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Well, thank you very much, appreciate everyone arriving back promptly and I will both turn it over to Dr. John Halamka for the Health Information Exchange Hearing report as well as to John to moderate and facilitate the rest of the afternoon. So, let me turn to Dr. Halamka.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, Jon, thanks very much. So, several of you joined the joint Standards Committee and Policy Committee discussion for Healthcare Information Exchange. There is a link with all the testimony on the ONC website that MacKenzie will send you out. I also wrote a summary on my blog.

What I would point to is the initial kickoff description by Micky Tripathi of the state of Healthcare Information Exchange in the United States is extraordinarily useful. A couple of things that he highlighted. So, the first he said, HIE 1.0 was a noun. HIE 2.0 is a verb and what did he mean by that?

All of us in this room have been involved in Healthcare Information Exchanges since probably the RHIO days, you remember that? And what was Healthcare Information Exchange, it was, oh a region would come together and it would have a bunch of servers and it would be a thing and you would sign up to use the thing.

Now in a world of Accountable Care Organizations what we're discovering is it's no longer a thing, a single service by a company or government, or a regional collaborative, it's more a series of functions that are necessary for a business purpose. So, it turns out well we've decided that we're going to form an Accountable Care Organization that requires us to coordinate care, do population health and care management and you know there's a whole lot of things we can do and some of it is FTPing files in the middle of the night, and some of it is creating central repositories, and some of it is creating web-based views, and suddenly it's no longer this thing we buy or subscribe to, it's a series of techniques we employ to accomplish a specific goal.

So, what Micky would tell us is that real Healthcare Information Exchange, the verb, is happening all over the country now, a lot of it is in private Healthcare Information Exchange necessary for ACO. Some of it is certainly in ePrescribing, he highlighted that ePrescribing is probably one of the greatest success stories for Healthcare Information Exchange in this country.

And when you think of the last 10 years, how in effect we ramped up from none to ubiquity and we did it around a couple of simple standards, and we did it by aligning incentives, in effect paying people and the value chain to use the thing and it's actually very much worthwhile considering and he does certainly believe that healthcare reform is accelerating Healthcare Information Exchange.

So, take a look at that presentation because it's again a real tour de force summarizing where we've been and where we're going. He did also come up with a nice construct looking at the simplest and less coordinated HIE, the verb, to the most coordinated and seeing where we're getting adoption where he talks about point to patient and point to point transaction level activities around a specific standard, and enterprise level HIE organizations, state and regional collaboratives and then national level collaboratives like the NwHIN going from least to most infrastructure and levels of coordination.

We then moved to, in fact let me just move to this next slide, we moved to panel one where we discussed Healthcare Information Exchange enabling healthcare transformation and the themes, I'll go in the next slide with some general overall themes, but the theme of this panel was that if you build it they won't come and that is just building a bunch of technology isn't sufficient.

The group we heard from, from Atrius Health, Camden Coalition, HealthBridge, Hudson Valley and North Texas Specialty Physicians said you need a compelling reason to do Healthcare Information Exchange. You need workflow integration. You need a business case and the technology, you know, is probably going to be an enabler but it's certainly not in itself sufficient. So, they told us look at the workflow requirements and the business value that you derive from the sharing of data and that is probably going to be your greatest accelerator.

So, here we are in the Standards Committee often talking about gaps and, oh, if we only build this standard then suddenly we would get adoption and in fact this group said, well thanks so much for all the work Standards Committee but it's actually business value and workflow that necessitates adoption and, as I think we'll see with healthcare reform, we were going to get organizations aligning to implement technology they wouldn't have otherwise implemented because now they're going to get reimbursed for sharing data. They won't be able to survive in a world of global capitated risk unless they're coordinating care.

The next panel we heard from talked about technical and business barriers and what we heard is, you know, it is certainly true that there are some standards that need to be worked on. A provider directory is an example and I know as a group we looked at provider directories and looked at federated provider directories and effectively said, you know, there aren't any mature standards that are going to do this and we heard...I mean, so I gave some testimony that said, in the absence of a standard that was mature and easy to use to the point that we've heard from Dave McCallie and others, you know, you just invent the thing that's going to get you over the hump.

So, you know, this is like a lesson from FHIR, right? So, that is for fast healthcare interoperability and resources what you do? Oh, well you put together a little RESTful interface with a couple of bits of XML and, you know, in a 2 page implementation guide you suddenly have fixed the thing that used to be a 10,000 page implementation guide and too hard for anyone to create.

And so we heard over and over that, you know, that there were some technology barriers, but, you know, mostly organizations that needed to get it done were working through those and sure if we could work on provider directories, if we could work on making templates of information easier to fill out, if we can engage patients and families with some easier standards that would be an enabler, but at the moment it had not been a true impediment to organizations that had business value and work flow to do it.

Next, we talked about, in panel three some governance barriers. This is really much about trust fabric and some challenges about how is it that we identity proof, how do we ensure authentication and how do we deal with authorization. These being three separate but related problems and is it NSTIC, is it the Federal Bridge, is it DirectTrust that is going to bring us all the tools we need. And, you know, at the moment I think organizations are still trying to figure out who they trust and how to ensure data integrity but there are initiatives like DirectTrust that are trying to move that forward in a unified way.

And we ended with the panel on consumer mediated exchange which really emphasized the notion that for all that we talk about provider to provider exchange and trust fabrics that it's hard to connect the last mile of EHRs in the community where you have thousands and thousands of practitioners some of which are in two doctor offices with no IT expertise and no infrastructure. And so the notion of sharing data with patients and families is key because this is an alternative to traditional Healthcare Information Exchange at the provider level. Send everything to the patient and enable the patient to share it.

So, let me just go to the next slide and highlight, if I were to summarize the day and what are the takeaways from the hearing. So, as I said earlier this morning when you read in the New York Times, you know, there's not interoperability of any kind, it's just silos of data everywhere. Well, go look at

Indiana, go look at HealthBridge, go look at what's happening in Massachusetts, the thousands and thousands of transactions are flowing every day for specific business purposes, whether that's lab sharing or summary sharing, or quality reporting, it is occurring.

There has been this shift over the last several years to the thing, to the activity. Payment reform is driving much of the motivation to accomplish this interoperability. And that just as Arien highlighted that we need to look at the strategy and then ensure the enabling technologies are there to support the strategy, we should look at the business drivers and then select the technology that will supply the functionality needed by the business drivers.

Very often Healthcare Information Exchange is done with standalone portals. I log into a separate website using non-common credentials, it's not my EHR's credentials. I have to use a different user interface or the likelihood of my finding a patient in this portal may be small. I have no way of knowing ahead of time if the patient is actually there. All of these are impediments to use, they're impediments to adoption.

I recently wrote an editorial, a paper for the Annals for Emergency Medicine which highlighted in a certain region of the United States that use of the HIE was for less than 10% of the patients coming to an emergency department and the clinicians basically said, so I have to stop what I'm doing, I am a busy person and it's going to take four or five minutes to login and search and I have no idea if I'm going to find anything and if I do it may or may not be helpful.

What I need is my workflow, my EHR to tell me, light comes on the screen data will be found in external locations on this person click here and suddenly without having to change my login or re-specify the patient context I get the information that I need. That's really what Healthcare Information Exchange adoption requires.

In general we heard from our testimony that we're on the right path, that is we are making steady progress. What was highlighted is in Meaningful Use Stage 2 we have unambiguous standards for transport, content and vocabularies. In Stage 1 we had a lot of optionality, we didn't have a transport standard, we didn't have the National Library of Medicine's curated vocabularies downloaded for free. We didn't have an easy to generate and easy to parse content standard. So, all the things that we've done for Stage 2 are good.

Now, a concern is that there are going to be tollbooths on the information super highway and so we had a very robust discussion about the fact that, gee, hey, Doug, when Meaningful Use Stage 2 was first constructed we just assumed that the Direct Project's protocols would be baked right into the EHRs, you could connect anyone and anything right from inside your EHR, it was magic, you know, it was SMTP/SMIME free, no postage stamps, it was XDR simple to implement.

Well, in fact what we're seeing in practice is now certain new kinds of models like, well we have an EHR and we're going to put in front of that EHR a set of constructs you must subscribe to because it's the combination of the EHR plus our separate construct that we charge you for that will do the interoperability using the Direct protocol.

And, so what you may find as we heard from one vendor, if customers of mine send data to customers of mine it is free. But if we send them to David McCallie it's \$7.00 bucks a click, you know, that is a very interesting challenge as we thought of Stage 2 encouraging technology and economic models to create data liquidity, in fact we may be seeing a series of HISPs each of which have a toll that may or may not be charged depending on who you are sending to and this is going to be a very interesting ecosystem if every time I click my toll goes from zero to, oh, you're going from here to here to here \$21.00 for you, that's going to certainly create friction.

We need to ensure that cross vendor exchange takes place and Wes Rishel made the comment we can't believe that Healthcare Information Exchange is going to be free, there is a cost to providing these networks and we, you know, digressed onto a couple of different models, the I'm in a foreign country, I make a cell phone call, I don't perceive what the charge of the infrastructure to get my call connected was but tariffs are somehow worked out by the industry and I just pay my cell phone bill every month and things just work.

Or, the train systems in America where CSX and Union Pacific send freight from the East Coast to the West Coast but you don't have an engineer stopping to pay a toll at a state border, it just happens. So, this is the area without a complete answer yet, but certainly, I think the ecosystem is evolving a little differently than the open data liquidity model we envisioned and still work needs to be done.

Now, for John Derr of course the comment that all members of the ecosystem, providers, patients, payers, LTACs, mental health providers they all must all be connected and we know that SNFs and LTACs many of them don't have EHRs, so ensuring that there's appropriate infrastructure for them to participate is important.

And as I mentioned earlier, the provider to provider architecture in itself is not the end-all. The patient engagement is a very important alternative architecture and that success, especially with things like Automated Blue Button demonstrations with the transfer of care summary standards, with Direct is sufficient that we should keep accelerating and emphasizing the need for patient and family engagement as an alternative architecture.

I mentioned to Jon that my father was hospitalized over the weekend in Los Angeles and just as I reported to you three months ago when my mother was hospitalized, medication reconciliation, discharge planning, it was all nightmarish and it was because still I, as a primary caregiver to my parents, lacked the transparency to all of the data inside and outside the hospital in order to facilitate with great efficiency and so we need to continue to work on that point.

So, in general I will say that the Healthcare Information Exchange Hearing was positive, that people felt like we had made significant strides and that generally our position isn't perfect but the trajectory is good. Now I would offer other comments from members of the committee who were at the Healthcare Information Exchange Hearing, anything you would add? John Derr?

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

I appreciate and I just wanted to add one thing. Most people in LTPAC came up and they said we want to help you. I mean, and it was a very, very supportive meeting for us.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Good. Yes?

Leslie Kelly Hall – Senior Vice President – Healthwise

And just as the opportunity for efficiency was mentioned about patients generating data and having that information in the record, and having the mindset that clinical documentation can happen in many different places and be sent in an automated way including the patient, the family, medical devices at home and others that would maximize the clinical encounter time and minimize the administrative burden for all.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right, in fact, to your point, I should just highlight for the committee that when I testified to the Policy Committee about your experience with the RFC, Christine Bechtel, said, John, you know, are you suggesting the patient generated data is invaluable? And I just want to clarify what my comments were. I said that, you know, Jamie, if we don't have a vocabulary that allows the patient to understand what medications they're taking or what problems they have and describe it in a way that then can be incorporated into our EHR systems, we may run into a challenge of data integrity.

Now, Doug, to your point about capturing structured data, and I completely agree with Christine's point, if we have things like activities of daily living, functional status, things that we can now give to the patient ahead of the visit that they can fill out in a structured way, that's data we would love to have and there's no question of data integrity with a problem list or medication list, it is novel structured data that is completely reasonable to say, and you know the patient told us their activity of daily today were these or their pain score was that, you know, that's great stuff.

So, in no way did I suggest that we should slow our patient generated data efforts, it is just that if we are going to truly co-mingle patient and provider source data, there's probably additional vocabulary that we may need to work on. Other comments for those who were there? Dixie?

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

First of all I thought it was a really good hearing, one of the best I've been to because it was so focused on the topic, you know, people didn't go off in different directions, it was an excellent hearing, but I just wanted to note two things. Several of the testimonies again pointed out the need for a better way to identify patients across a...particularly across organizations, we keep hearing that and it is a huge issue.

Secondly, just for this committee, this isn't a huge challenge, but I think we need to attend to it, is that it was pointed out that if a patient downloads their own health information and they then want to send it to another provider for themselves, that that download needs to be digitally signed or the recipient is unlikely to trust it and I think that we should pay attention to that.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Both accurate points. And Walter did you have a comment?

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

Yes, a couple of quick comments, two. Great summary by the way John. The first one is that we heard about probably a very important third model in terms of...I mean, we've heard through the presentations, you know, the push and the query and response and the pull and all these concepts, but we heard another one that really came to, as somewhat of a surprise to many people, but the reality is a lot of these "exchanges" are happening that way and that is access.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right.

Walter Suarez, MD, MPH – Director, Health IT Strategy & Policy – Kaiser Permanente

So, really allowing the providers to go to another provider and access their system and view so the access and view have become sort of an important alternative and mechanism to achieve what some people have mentioned and referred to as exchange and in reality in these situations there's really no exchange happening this is purely an access and view for the provider to see, you know, information about the patients and that was one very important one that I think was critical.

The other part is really, and I mentioned this at the end of the hearing, is we didn't hear a lot about sustainability concepts and models of the HIEs in terms of organized efforts and I mentioned, you know, how in reality many of the current HIEs are facing what I called back then a fiscal cliff referring to what we are facing as a country or faced a few months ago, but the reality of that is at the end of this year and through this year, and probably early next year many of the grants that have been issued under the cooperative agreement for information exchange will be ending and many of the state HIE organizations really don't have yet necessarily a true sustainable model.

So, I kind of raise that as a concern because a lot of the organizations that were actually present were organizations that were reflecting on their model and their ways to achieve success but on a much smaller scale and in many cases very small communities in Texas and in other places and so it was important to, in my mind to raise that concern about the fiscal cliff I see that many HIEs are going to face in the near.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, to Walter's comments, four models were raised at the hearing, so the standard one being push. We use Direct to send a package from place to place. The second being pull where we use the NwHIN exchange standards, use a record locator service, a master patient index, discover where records are, query them and get a summary back.

Then there is the Directed query, instead of having a record locator service or centralized infrastructure, that I send a query to a known holder of records and synchronously or asynchronously a package comes back to me, in effect I push a Direct message to them and in response they push a Direct message back it doesn't need to be a completely synchronous event and as Walter highlighted, this last one, view, which is kind of interesting, something that I've done a lot of and I've sent the implementation guide to several folks where it goes something like this.

I knock on your door and say here is a security credential, it could be a SAML assertion, it could be a secret key trust me. Okay, I trust you. Here is the patient that I know has told me they're at your institution, right, there is no record locator service or big infrastructure but they've told me the doctors, you know, using the EPIC system at your institution and so name, gender, date of birth and other demographics are presented and given that I am trusted and that I have specified in a RESTful URL the patient ID a web page pops up and it a web view of the problems, the medications, the allergies and whatever and it's true that the UI might appear different in EPIC or MEDITECH or eClinicalWorks, or whoever, but a doctor could say it's the web. Backwards, forwards, click here. I can figure it out and you can put these kinds of view infrastructures up in days because it's true just secret key or some trust fabric and a URL and you're done.

Now, Arien and Dave, I think you had comments may be related to this? Let's start with Dave.

David McCallie, Jr., MD – Vice President – Cerner Corporation

Yeah, no I think we've done this in a number of our HIE implementations as you have done in Massachusetts and it's very well received compared to just a simple list of documents because you can take advantage of the summary views that are generated by the remote EHR which in some cases are more easily assumable than reading through a CCD that has lots and lots of problems and medications and allergies, but isn't really designed for clinician consumption. So, I think that's an underappreciated easy way to get high-bandwidth interchange.

And it occurs to some of us that have pushed for that that the emerging FHIR work might be a natural counterpart to that to allow a download from something that you see on that web page. So, if you see something that you really need a local copy of then use a simple RESTful transaction to pull it down into the record. So, it might be a one/two combination that is easier and yet more powerful than some of the current models.

Leslie Kelly Hall – Senior Vice President – Healthwise

John, I would offer that viewer, this is Leslie, that the viewer approach can be equally beneficial to claims and then we start to get other nontraditional providers included in the record and prepare for a common view, whether that ACO is being serviced by a payer or provider organization. So, encourage that further look.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, the reason David's comment is so salient, the one problem with view is imagine the following scenario. Arien, you come to me in the emergency department and I do a view of David's Cerner System and your potassium is 2, oh, my God, and so I just fill you with a boatload of potassium. Oh, and then you develop an arrhythmia and die and then I go back to this viewer and it says your potassium is 5, but I swear just 5 minutes ago it was a 2 and the reality is if I make a clinical decision and I need a persistent copy, I could in fact download a persistent copy into my system if needed.

David McCallie, Jr., MD – Vice President – Cerner Corporation

Yeah, assuming that...for that reason alone. The other thing, just since I have the floor in the hearing that I think there were some really interesting discussions and I think you mentioned it, but I paid especially close attention to it, because the Tiger Team is working on, you know, what are the simplifications that we can make to the consent and authorization process to support the targeted query model.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right.

David McCallie, Jr., MD – Vice President – Cerner Corporation

And the discussion of interest was the shift in the mindset that it's up to the remote party to make a consent release decision whereas you can imagine a new model that says if the requesting party can assert the existence of a treatment relationship and even better the consent of the patient who is standing right there with them at the bedside that you could transfer the decision to release the data in a sense to the person who needs it rather than to the person who is nervously hoarding it and not sure what to do about a release.

So, I think the Tiger Team is going to be meeting I think maybe even tomorrow there is a call where we kind of push that model forward to create, what I think Arien used the phrase, a moral equivalent of a safe harbor. We can't write a new law but we create best practices that say to people if you fit these criteria, these constraints you can make this consenting process much smoother and yet still be totally following the patient's wishes.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And so there are two substantiations of that model that we should highlight, the first is Surescripts. So, Chris in your former incarnation remember that Surescripts effectively says you can go do a medication history query as long as you assert that you have obtained the patient consent by whatever means, was it oral, was it written, was it in the file, was it...you know, however you did it as long as you assert it's okay.

Another is the SSA has in its mega hit project the notion that you walk into an SSA office, you the patient sign a piece of paper, SSA then does a scan of that piece of paper and in the query sends the scan of the piece of paper with metadata in XML saying we the SSA have achieved a signed consent. If you really need to look at it here is an attached JPEG, but most don't, they just save the digital image if they ever need it for auditing purposes, they trust the metadata and it's all simply in the query.

It is not, as we heard, I think from the Information Exchange Workgroup at one time, a three-step exchange, right, say, hey David you've got a consent form, great send me the consent form. Oh, I'll fill out the consent form, here's your consent form now send me the data, which is a slightly impractical architecture. Now, Arien, I think you had a comment?

Arien Malec – Vice President – RelayHealth Clinical Solutions

I was just going to comment on the surprising effectiveness of view and potentially that as an opportunity for some basic standards. I would note on that last point, that what we heard from the EPIC to EPIC experience, which I think is an interesting proof point or existence proof of this model, I think the quote was something like two thirds to three quarters did not require additional authorization in order to make the data exchange happen because they established a common trust framework that was sufficient for the parties to respond and so it's an interesting test case and there was some thought that maybe some of the additional cases where either state law was more restrictive or whether the health system had made a more restrictive interpretation, but at least there's a hope that for most cases we can get that to be a one step process.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right and so EPIC testified that they a highly configurable consent model but that most of their organizations that said treatment, payment and operations we're going to coordinate your care, you've signed a general consent along the way, we're just going to do this exchange and you will like the quality, safety and efficiency that results and that is sufficient.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

To keep us on task, want to segue way into a...that was a terrific report and I want to thank you for your leadership and participation in that and all the committee members who are present, but what a terrific summary and discussion and you've heard me say this before the difference between hope and optimism, hope is a feeling, optimism is a feeling based on data and this is...it should give us all notes of optimism about the emerging ecosystem.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, let's move on then to Jodi and to Doug for the ONC update.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

John?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Apparently my virtual card fell over.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Oh, well sorry, I can't present and look at my iPhone at the same time, so please, Wes, your final comment?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I've never believed that you couldn't do at least two or three...having gotten e-mails from you while you're mountain climbing I assume that...

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Oh, well.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

That operation that separated your brain size was successful and made you a multi-processor.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thanks.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

The one question I wanted to ask you is that you earlier, just a few minutes ago, made a statement about the need for a physician to want to see information for there to be the kind of spontaneous on-demand query that you're requiring and I think we've recognized for a long time the physician has to, a, look at the time it takes to do a query against the probability that there's data times the probability that that data changes what they're about to do and that makes it very hard and yet you're also saying the popularity of the view mode. So, can you help us understand what are the circumstances where the view mode has been successful in that regard, where there is general concern about leaving physicians to HIE and not being able to get them to drink doesn't seem to exist.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Sure, so the view mode that I've implemented in Massachusetts gives the physician a button to click on when there is data to be had and therefore they know it's going to take less than a second, it will require no additional sign-on, it will require no additional patient context and 100% of the time you're going to get a pleasing result. So, you've identified this characteristics exactly right and in our case we have enough affiliations in our community that it's considered very bad form to not click on the button and coordinate care, get medications and problems, get care plans correct, etcetera. So, the physicians are motivated to do it knowing how fast it will be and the high likelihood of success it will offer.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So how do you know whether to light up that button?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I can send you the specification but it goes something like this, it sounds a little strange, Wes, but we know your primary care physician, we know the affiliation of your primary care physician and we can show when you're visiting say our hospital that your primary care physicians EHR has a one click link that we will light up and tell you to click on. So, part of its a doctor level. We've also created some web services where we can query for an exact match and then show a link as available if that query came back with success.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so you can get the probability that there will be data pretty close to one?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Correct.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

The probability that the data will be useful is still a judgment the physician has to make?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

But if they're in the ER for a laceration they're probably not going to do it, but other circumstances they might.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

But accurate medication list turns out to be useful for most.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, okay, thanks.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great. So, let us turn to Jodi and to Doug. Jodi has a few slides that she's just going to give us the ONC update and then Doug will continue the discussion that we had from this morning should there be additional commentary. So, Jodi?

Jodi Daniel, J.D., MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Since it's more than one slide I figured I'll come up to the head of the table so folks on this side can see me. Good afternoon everyone. I'm just going to do...Doug and I have decided that we're going to start doing the tag team both on Policy and Standards Committee so you all get the benefit of some of the policy updates and the Policy Committee gets all the benefits of the Standards updates and I'll also try to bring some of the discussion from the Policy Committee to this committee so that you all kind of know what was just taking place a week earlier in case you didn't have an extra day to just sit and listen.

So, I'm going to do these pretty quick, high-level and would be happy to dive in deeper in future meetings on any topic area that you all would find helpful but I'm going to cede most of my time to Doug so that we can go back to talking about some of the work planning.

So, just the FACA update. As you all know, we did a call for nominations back last summer with one slot on the Health IT Policy Committee and 12 slots on this committee, on the Standards Committee. We received 153 nominations and we are down to the wire. We are almost ready to make the announcements of the new members and we will do that in early March. We're hoping to actually have those new committee members begin serving at the March meeting. So, stayed tuned, imminent and we will let you all know as soon as we have those names to announce.

Also, I wanted to let folks know that GAO is currently accepting nominations of individuals for two openings on the Health IT Policy Committee. They are looking for somebody with expertise in advocating for patients and consumers as one of the slots and a member of a labor organization representing healthcare workers for the other slot. Those two slots are coming up and they are appointed GAO by the comptroller. Letters of nomination and resumes are due to GAO by February 22nd so just a couple of days and I will read this out so folks don't have to look for where to send nominations, it's hitcommittee@gao.gov so anybody who's listening, who's interested in the Policy Committee and that represents one of those two areas should consider nominating themselves or nominating somebody they know for those slots and GAO handles those nominations for the Policy Committee.

New Workgroups, so we have two new consumer Workgroup that we're going to be kicking off very soon. We received nominations through our new nominations process online. We're going to have a Consumer Empowerment Workgroup of the Policy Committee and one of the Standards Committee. We did originally have a Consumer Power Team that we kicked off to give some feedback on the rules back in the day and we've gone through a formal nomination process and are in the process of selecting and getting confirmation on members for that Consumer Workgroup both the Policy and the Standards Committee.

Leslie Kelly Hall has been really helpful in giving us feedback for membership for the Standards Committee and we will be setting up a process to make sure that we have coordination between the Policy and Standards Committee Workgroups so that they're working collaboratively and building on the work of each other. On this one we will announce members next week. So, stayed tuned.

We also have announced that we will be forming a new Accountable Care Workgroup of the Health IT Policy Committee on February 1st we announced a call for applications, we're currently reviewing those applications that we received and we'll be announcing that shortly as well. That is on the Policy Committee side, but, you know, as you know, the discussion from the Policy Committee has bearing on the priorities and the work and discussions here as well. So we will keep you informed as that Workgroup kicks off as well.

At the last Policy Committee meeting we did finalize our Policy Committed work plan. I can share that with folks if we haven't done so, so that you can see particularly when we're having our Chair's call to make sure we're coordinating the work of the two groups, the two committees to try to align those efforts and see where there maybe opportunities for this committee and if we can get that out to folks on this committee as well.

Okay, so we just held on February 13th a Clinical Documentation Hearing with the Health IT Policy Committee, just wanted to give a couple of takeaways that we got from that discussion. It was a day and a half hearing. We had one day of hearing and a half a day of discussion afterward, which was great, because we were able to keep folks together and get them to start thinking about what they heard right after they heard it, so that was really helpful.

We heard loud and clear not to be too prescriptive when we're talking about documentation in the clinical record and that there is no one method of documentation that is aligned with good quality of care so that there should be some flexibility in how folks can document information in the record and by way of example the Department of Defense noted that they use both voice recognition and structured text to support their care processes and they've found that to be very successful.

We heard that we should encourage alternate data entry ideas as a way to relieve burdens on providers. So, things like using medical devices, some patient generated information where the patient has information that could be incorporated into the clinical record. We also heard that sharing of information with a variety of folks, both the patient as well as the growing care team, was really critical to help with accuracy and that this was a way of promoting better quality and integrity of the data in the record.

So, with respect to some next steps, we heard from the Workgroups that for Stage 3 that there...well, so in Stage 2 there is an electronic note objective that is a menu objective and there was a suggestion from the folks in these Workgroups to make that a core objective for Stage 3.

They're also formatting an objective around documentation specifically and thinking about documentation of the clinical encounter, having the equivalent of a track changes application within the vendor's EHR so somebody can see the clean note but also be able to see any edits that have been made to the documentation.

They also talked about when constructing a note using productivity tools that this would help with identifying the source of the data so if it was something that copy forward having that indicated in the notes so somebody knows that it was not directly typed in by the clinician during the encounter.

Those are a couple of takeaways from the Clinical Documentation Hearing and expect that we will have recommendations that will go up to the Policy Committee with respect to clinical documentation.

On Health IT and patient safety we had our Certification and Adoption Workgroup make recommendations that were accepted by the Policy Committee. Those recommendations included having a menu option for providers to attest to performing a safety risk assessment, this was something they asked for comment in the RFC, to encourage voluntary reporting of Health IT related safety events to PSOs and we know providers do voluntary reporting of safety events, focus here being on Health IT safety events as well as using Health IT to support reporting to patient safety organizations.

They talked about, in their recommendations, having for Stage 3 the EHR to have the capability to have a convenient mechanism for users to capture safety risks and incidence, to do this automatically such as automatically capturing screenshots, allowing a user to have text so that they can edit any information with regard to safety events and they talked about this capability having low overhead to the EHR user in order to encourage safety reporting.

They also talked about vendor reporting to PSOs and encouraging that as well as vendors partnering with provider customers with respect to safety events and reporting of safety events. And finally, with respect to standards and Health IT safety, they talked about the use of surveillance subset of the common formats which is expected in the third quarter of 2013 for EHR capture of events and unsafe conditions.

We, at ONC, have still been working hard on governance, health information exchange governance. We heard in the RFI that we had put out where we got a lot of feedback that we need to do some more listening and that we should hear from folks who are on the ground and directly engaged in health information exchange. So, we took that input to heart. We've held two open listening sessions on governance. The first one was January 17th the second was February 14th it was our Valentine's present to everyone.

We had a total combined attendance of 1070 people who had participated in one or the other of the listening sessions. So, really good turnout. We focused on getting input to inform ONC's activities and assist in advancing our governance goals regarding increasing interoperability, decreasing costs and complexity of exchange and increasing trust.

We heard a lot of themes, I'm not going to go into too much detail on this, but a lot of themes about trying to address the variability of policy and business practices, the variability among trust policies as well as the standards variability. So, kind of across-the-board some challenges that came about from different folks doing things different ways and how we get some harmonization of that.

We also heard about the need for alignment between federal, regional and industry approaches and regulations including compliance and certification testing and requirements. So, we are moving forward. We talked about our plan to...we've announced that we will be putting out cooperative agreements for exchange solutions, that we will be hosting a national HIE governance forum by folks that are engaged in governance of health information exchange to learn some best practices and approaches for some operational challenges.

We will be putting up governance guidelines for health information exchange so that there's sort of a north star of what we think folks should be shooting towards with respect to their approaches to governance and health information exchange as well as an approach on monitoring so that we know how things are progressing with respect to health information exchange and where there maybe opportunities for us to intervene or to leave things to the market.

And last, but not least, I just wanted to let folks know of an event that's coming up and something that the Policy Committee is very interested in. There was some discussion in the Policy Committee about disparities and digital divide. We are holding an achieving eHealth equity summit it will be sponsored by ONC, the HHS Office of Minority Health, as well as in partnership with Zerodivide and Health 2.0. This event will taking place on February 21st so tomorrow at the White House with the purpose of understanding how we can achieve eHealth equity for underserved and minority populations, how we can improve customer access and consumer access, and utilization of information technology in underserved communities, and how Health IT can improve outcomes for the underserved.

We will make the proceedings, a summary of the proceedings publicly available for folks. This is a small event at the White House Conference Center and so we will publicize the discussion and the summary of the events after they occur and that is my update. Thank you very much for your attention.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, any comments/questions for Jodi? So, I recognize post lunch this is your didactic session there will be a test later. Thanks very much. The information sharing as you pointed out is important for coordinating our two groups if there is a theme we've heard over and over at this meeting its the importance of coordination between Policy and Standards.

So, Doug, now that the remainder of the time has been deferred to you were there additional items that you wished to present or do you wish to go back to some of the comments earlier on the work plan and open the forum again?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

So, thanks, my initial goal was to sort of do a little bit more discussion around say structure data capture and some of the other work but frankly the two hour discussion that we had this morning was the standards update, it is basically a description of all the things that we've either got in-flight or that we're thinking about.

So, to me since it is more challenging to get this group together and to talk, I would much rather if you would like send out a slide presentation to everybody about the didactics and continue the conversations that we had this morning. To me it would be so much more valuable and see if we can't tee up some more things.

I can tell you some of the things that I've got listed here as my to do items. So, one was to really get some additional insight into what's going on in esMD work I think there was a concern that there was no look at some of HL7 standards around this and I think it would be appropriate for us to bring that back to this group and give up date.

I think there was some desire to learn a little bit more about FHIR and what that is and what isn't and kind of where it is in its maturity and make sure that we have a clear understanding of how that...while that appears to be a potential game changer and how we might attack some of these challenges, what's the right time to do that and how could we do that. So, I think that's another thing that I would like to do.

I put a note here about an update on our implementation and testing platform, because I mentioned it a couple of times and it's one of those things that I think it's going to be important as we try to turn this ship and have this driven more by business drivers and the results of implementation, getting a sense for what that is and what we're trying to achieve and work on with that and so that's another update that I had.

A couple of things, these are on your list, but I had them on my list as well, one is education of other teams regarding the Power Team, work with Dixie to figure out how to do that so that we can broaden the experience with what that team has done and perhaps add additional refinements to that to see if we can get a broader input and so Dixie you and I should probably just touch base about that or with your Workgroup and see if there's a way that we can do that.

And, let's see if there's other things, yeah, and then many of the comments that Arien brought up about trying to make sure that we've got sort of integration in all of the work that we're doing. I think one of the challenges that we have is that there's a tension between those things that we need to get ready for, you know, the next three months or six months or whatever and those things that really require a deliberative and focused effort to try to get us to those foundational elemental building blocks, if you will, and to be able to articulate how these pieces all fit together and why we're doing the things that we're doing with regards to this.

So, those are the things that are on my list. I'm sure you have other things that you'd like to put on my list, but maybe we can start the conversation there, that's just my sort of summary of some of the conversations and if there other things that we need to do, I guess some work we're going to do with the Workgroup leads to get them together to make sure that we've got the right assignments and then to coordinate with Policy to make sure that we are all on the same page with that as well.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, opening up the floor to continue the dialogue from this morning and of course we had a final to do based on Arien's suggestion of doing a strategic link up with the Policy Committee and then dovetailing that with maturity and then coming up with what would be a revised work plan.

Now, Doug mentioned something to me at lunch that I think is worth highlighting and that is...and Jon, you've said this many times, if we don't build a foundation of technology it's a little bit hard to satisfy even the most urgent policy mandate and that is unless we have a comprehensive strategy for CQMs based on structured data capture, query response whatever it is we want to do, you know, you wonder on the one hand we want to do what Arien said prioritize our future work based on strategic imperatives, but on the other hand at times you may want to decouple some of the technology work from the Policy work to build a foundation that's going to be necessary for future policymaking. So, it's an interesting tension.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

I think I used a more colorful analogy. I said you can't build a skyscraper by nailing 10,000 dog houses together.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, you could it just wouldn't be say very safe.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

But that really goes to sort of design with purpose to try to create something together so that we may have a whole bunch of activities that we can put together to create a structure but what we really need is we need a way of thinking through how those things should work and thinking about how the various kinds of standards that we have, the kinds of initiatives that we have making sure that those things all sort fit together.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So comments, I mean, we did hear from Doug some of the to do items he has, some of the future presentations and briefings that we would like to hear about what FHIR is all about, is it sustainable, is it going to be the wonderful replacement for HL7 version 3 that we think it could be. Where are we with the detailed clinical models, etcetera. But other comments? Or are you all just waiting for the Workgroup Chairs call where we're going to just resolve all this?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

John?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So, I think that just piecing together things Doug said at different times we're always going to be walking back and forth across the center of a teetoter on the issue of how much coordination leads to monolithic somewhat impeccable solutions and how much...creating separate potentially stackable solutions allows for responsiveness to the economic drivers that ultimately determine the success of interoperability anyways and I don't know that there's a right answer.

I do know that we...the monoliths tend to face various kinds of technological difficulties from given pieces of them becoming obsolescent to what somebody called version skew once where different organizations are using different versions of a technology.

But, I think that the actual...one can argue that the actual need is to identify the priorities per Arien and identify pieces of the solution that either fill in alternate parts of the puzzle or that are themselves alternatives depending on how technology goes but I'm stumbling a little bit here, but I think that's somehow how we need to shape our work.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you. Jim Walker comments?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

So, when we think about usability and whether a standard is cumbersome for vendors to incorporate that's a critical form of usability if it's incredibly hard for vendors then everyone downstream is going to suffer. At the same time, in one view of the world, the vendor's job is to deal with difficulty and complexity so that the customer, the user has what is a, deceptively I guess, simple view and set of things that they have to do and I think as we try to figure out when, and Wes, I'm sure you're right there is no right answer, but as we try to figure out when we should keep using some terrible standard because at least most of the people out there in the trenches know how to deal with it, and when we should move to a new standard, one of the critical issues is what's going to happen to all the people out there who have cobbled something together that more or less works as against the vendor task.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yeah, so a couple years ago, if the folks remember the HITSPC days when sometimes the standards were overly complex and the implementation guides overly long I pointed this out to certain organizations and they said our implementation guides are perfect it's all your implementers that are not smart enough, yeah, okay, wouldn't it be ideal if we had an implementation guide that a 16 -year-old with XMLSpy could implement in a day. So, any well, point well taken. David?

David McCallie, Jr., MD – Vice President – Cerner Corporation

This is David, I want to remind Jim that he has changed sides and he should be careful about smearing the vendors now that he is one of them. So, be careful what you wish for you may get some difficult standards to go implement.

But, more to a serious point, I think that Dixie's Workgroup on the how to evaluate a standard which Arien and I, and Wes and some others participated in was a real eye-opener in making it clear that there are just many, many different facets of whether a standard is going to work or not, some of which are about the elegance of the internal standard, some of which are about the scalability at national scale, it might work beautifully within an institution but fail miserably at national scale and so forth.

So, that work that we did on that committee it was useful stuff to help think this stuff through and none of these are easy decisions I think I agree with everybody on that.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, any other comments for Doug? I mean, obviously we do have a body of work ahead where we will attempt our Chairs level to coordinate and re- evaluate the work plan to make sure it dovetails with strategic imperatives. Doug, other closing comments?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Well, I think one of the other things that would be helpful is, you know, Wes has said this before when you change the consensus group you change the consensus and I think some of the challenge that we have with the standards and their complexity is the participation of who shows up and who develops those standards.

So, I would welcome the collective wisdom of this group to help us do a better job at figuring out how to do that and we've tried a lot of different things and not always been successful. I mean, we've tried creating a place that was different than the existing standards development organizations. We tried to create a way that we could engage across SDOs and across vendors. We tried to create focus in the work that's going on.

There is a tension because there's a lot of stuff that vendors are doing right now, they don't have a lot of time to necessarily engage and then when it comes out then it's not quite what they wanted and so I don't know how to solve that problem. I guess I just sort of throw it out there as to say we're trying a lot of different things. I don't think we've been entirely successful yet and, you know, some people have argued that v2 was a really successful standard but in large part it was really driven by the vendors that were trying to do intra-enterprise interoperability and try to figure out how all those systems would talk with one another and they kind of figured it out.

We have not yet sort of reached a place where we've got that kind of engagement as well and I would in fact challenge us to expand it beyond just vendors but to get to the innovation community and the folks that really don't have any time to do the kinds of things. I mean, is there a way that we can create a place where we change the equation so that it is driven by business models, that it is driven by those sorts of things.

And, you know, we're going to try and, you know, S&I 2.0 to try to engage the implementation and testing to see if that's a way to engage the community as they're implementing and that we can help support that.

So, I think a lot of the problems that we talk about or a lot of the criticisms that we have, we have to try to figure out how to change that and it's going to require engagement in a way to sort of get those vendors and the communities that really we care about getting into this space to be there at the table and I just would, you know, I don't have a solution. We keep trying different ways to do it, but I think it would be helpful to figure out what's a good way for us to have that kind of engagement.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And certainly you've said over the last couple of years that we've had multiple different processes for multiple different problems and that is sometimes we as a group can harmonize. Sometimes the S&I folks if it's problems this big can harmonize and sometimes you need an Arien Malec because the problems this big and you have an initiative that stands alone. So, David, did you have a follow on to that?

David McCallie, Jr., MD – Vice President – Cerner Corporation

Yeah, Arien, you put your card up first, were you going to respond to Doug? So, you must be tired of listening to me, so let Arien go.

Arien Malec – Vice President – RelayHealth Clinical Solutions

This notion of how do you get people to engage, and I'm repeating myself and I'm aware of that, but one of the observations that I had spinning up the Direct Project and then the first wave of S&I Framework activities was that everybody knew that at the end of the day Stage 2 had to do something about transition of care, Stage 2 had to do something about getting data to patients, Stage 2 had to do something about getting electronic lab information to the provider and that gave a really good platform for saying, okay we've got to do something here so we spin the Direct Project up and we challenge the community to go solve that problem.

We've got two competing lab standards, none of which have ubiquitous adoption, so HL7 go solve that problem and we'll help you. The CCD isn't where it needs to be both in terms of the documentation and in terms of the structure. HL7 if you want there to be one document standard go fix that and knowing where you get to...and any of the vendors who didn't participate in those activities at least knew exactly what was going on and they knew that at the end of the day it was no surprise that the Stage 2 NPRM was going to include, unless those activities horribly failed, was going to include some reference to those activities.

And so stakeholders knew what was going to happen and they were able to prioritize their effort around getting the work done. I can tell you right now that we have folks inside our organization, the larger organization, McKesson, who follow the S&I Frameworks and monitor all of the activity and they're confused. And there isn't that clarity of purpose that says I know at the end of the day I'm going to need to solve this problem and so I'd better get on board.

And so the best forcing function that I know of to get engagement is to know that you're going to own the problem at the end of the day and you can either be part of the solution or you can just accept what comes down the pike and that's really the only way to get that level of alignment.

I'd also note that if you look at other industries the way standards have proceeded is not a standards development organization brow beating vendors to go get stuff done it by and large is vendors who need to solve a problem for their customers where the business challenge or the policy challenge is driving the agenda saying we need to solve this problem and is better, we sell more, we get more usage and adoption if all of our products solve this problem in the same way so let's go get this job done and that's what happened in Wi-Fi, it's what happened in USB, it's what happened in...if you look at any successful standard that tends to be the pattern of adoption.

So, this is not a new principal. The principal that you start with the end in mind and then you engage the vendor community and the vendor community knows that at the end of the day they're going to implement it and so they've got the incentive to participate.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you. Jim?

James M. Walker, MD, FACP – Chief Health Information Officer – Geisinger Health System

And that same argument is true for care delivery organizations. If it's clear what's the general shape of MU3 or whatever it is then at least some organizations will have the capability to start saying, okay, we've got to redo our processes now. We can't afford a separate module for the ED anymore it's got to be the same thing as the hospital EHR or we're dead and that will take us a long time to transact and so we need to start now, that's one thing.

The other that concerns me Doug is that as long as there is a table, the table is in a location and the table is expensive to get to and only organizations with very large resources will have the time and the money to get to the table with someone capable of representing them well.

And so in the same way that we're trying to explode the point of care I think we ought to explode the table and I think you would get more, we all would get more better information if instead of having a hearing we said okay let's identify the questions we want to answer in this hearing and, you know, have a methodology for it and also leave some open ends so we find out stuff we didn't know we needed to know and hire somebody NORC or somebody else to go out and interview the people that know what we need to know to make the next move and that way it could be for doctor practices, it could be 100 hospitals, it could be small vendors and others.

And if, you know, there are methodologies for doing this in a way that would, you know, sort of then do thematic analysis and sort of an integration of all of that information that would be really usable and useful and you can, I mean, part of that methodology is that you can say, okay now once we've sort of identified the big themes and we start to see, you know, what we think are common themes, now we'll create a survey questionnaire and we'll send it to all the stakeholders that are relevant. I submit that you would have far better data, you would have far better information on which to act and the total cost would be cheaper.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Now, David, did you have a closing comment on that?

David McCallie, Jr., MD – Vice President – Cerner Corporation

No, I echo those two thoughts. I don't have much to add believe it or not.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Doug, final comments and then we will move to public comment?

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

Let me just say I agree that we...you know, part of what we're trying to do is get the business drivers and the problems that are trying to be solved up ahead of the curve and see if we can't kind of turn that ship. Clarity on what's important, we've got a whole list of stuff here we've sort of gone through hopefully with policy and with the technology we'll be able to get to that clarity.

I will say this, that there is tremendous interest across many federal agencies around the structure data capture activity because it's a general-purpose tool that can be used in lots and lots of different places and may give us yet another kind of way of assembling information together into containers that allow us to get to big data analytics and things like that.

So, in terms of priorities I think structure data capture is certainly something that we think solves a host of different kinds of problems with a general-purpose solution and I think that's important. I also think that we...another priority I think is if you think about structure data capture as a way of getting additional information into and integrated with the electronic health record, I think another important stream is to get data out of that electronic health record in a consistent way.

And we need to have discussion about what's the best incremental path to getting there but I think we need to make sure that we provide value to the providers who are being asked to add a lot of this information that we do then expand that to people authorized in a targeted way to get to that information and then to beyond that to think about distributed queries, that may be too far of a bridge for Meaningful Use Stage 3, but we have to think about how those things incrementally would do.

So, from my perspective there's a whole bunch of stuff on this list, there's a whole bunch of things that we've been talking about, but Meaningful Use was supposed to be in large part around putting a down payment on the learning healthcare system, on data analytics, about having distributed query and having intelligence that can be gained from the data.

So, if that is indeed one of the goals that we have for Meaningful Use Stage 3 and certainly it's a goal that we have in the long-term the two priorities that I see are about structuring data that is at more granular and can be assembled to solve particular use cases and particular problems. And the second is making sure that we can open up the data out of an electronic health record in a way that allows us to...just as Blue Button opened up the data to consumers we have to make sure that there are ways to do that within the electronic health record. And I think those two kinds of conversations are the things I hope we'll have as we go forward with this committee and with the S&I Framework.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, thank you. I think Jon I'll turn it back to you and then we will go to public comment. Oh, I didn't see your card, please go ahead.

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

I took it down.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Oh, okay, sorry, my peripheral vision is not what it's used to be. Please go ahead.

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

I just wanted to point out when we had the HIE, the Health Information Exchange Hearing, several people pointed out, Bill Spooner probably most emphatically, the need to really converge Meaningful Use with participation in accountable care arrangements and in today's discussion, I really haven't heard much of that, but I do think if I were a provider out there having to deal on the one hand with Meaningful Use, on the other hand with ACO involvement I would feel somewhat overwhelmed and I agree with the people in that hearing that I think we need to converge those two in our own minds so that it doesn't sound like they're getting hit on both sides by two different things but rather there's a single story here and I think that's important.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Right, certainly on CQMs, I mean, there's an attempt to try to skinny down the number of new requests and align them with ACOs and certainly you would imagine that as part of the interoperability activities we're supporting ACOs so that there is, you know, not dozens of new initiatives but in fact some common themes.

Doug Fridsma, MD, PhD, FACP, FACMI – Director of Standards & Interoperability – Office of the National Coordinator

John, just to that point, it's so important Dixie that as we're building this technical infrastructure that we do it in such a way as to not have it unable to support Accountable Care Organizations or new models out there. I think that there is this, you know, we are in large part driven by the needs that we have within Meaningful Use but those are really in service to a much broader goal which is reducing cost, making sure that we improve health and we improve health care and regardless of the models the technology should support those things.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, well that is a good note on which to close discussions on this convergence, really is a terrific discussion. We wax broadly on issues of policy. I would just summarize on a couple of principles. First, I heard a reiteration of one of the things that we've spoken before which is that our functional task shouldn't outstrip our data model.

And as we approach the solutions, the functional tasks that are required in terms of the Policy Committee we need to make sure that we're building the data model and sometimes those are things, Doug, that as you articulated are directly in support of the next trench of Meaningful Use standards there are other things that build that data model to allow a broader learning health system and all of the other capacities for learning, convergence support of accountable care and all of its guises, etcetera.

John, you invoked Perlin's rule is don't try to hang the ornaments until you have the Christmas tree and so don't let the data model...don't let the task try to get too far ahead of your data model. Now in terms of moving that forward, Doug, I think and the group really spoke eloquently about the policy priorities. And into this next trench of work as we have the Co-Chairs Committee with Paul Tang, etcetera, look to you and to Farzad, and to Jodi to help guide us in terms of those policy priorities.

Obviously, major policy priorities in support for accountable care, improving the value of health care, improving the health of the population, etcetera. But, to the degree to which you can make those explicit and related to particular pieces of the work that we've talked about today that are encompassed in this work plan that's also helpful.

The other flip side of that is that there may be things where you say, gee, you know, this is laudable but there really needs to be a policy to support it. I think John Halamka you reported, eloquently, that some are struggling with the business model for sharing information as aggressively as all of us, certainly in this room, would want be we patient providers, payers or otherwise and I think that's something that we count on your office to also transmit when there's work that yes to fall into a particular business case.

Imagine a world in the here and now where actually there was a premium on sharing information, in fact even a penalty on not sharing information one wouldn't have to invoke the future world of fully substantiated accountable care to see a very different business case for really stepping forward smartly, that's just speculative, I offer that as a private citizen, but just noting that the policy dialogue is one that can also create the conditions that draws forward all of the activity.

And in summary, the third thing and Jim and Arien, and others spoke to this point, is that for those who are trying to lead or follow in terms of meeting all of the Meaningful Use and more importantly the intent behind Meaningful Use, the clearer the trajectory the easier it is to anticipate needs, to build products, to be poised to implement product and wanting to be sure that we contemplate all communities be they LTAC or patient's home, other extensions of the ecosystem that are fully part of the ecosystem helping folks understand what they can do at any given point, what they might do in the future and how they get there is certainly helpful if not most specifically for those vendor and provider communities that have some immediate tasks in this process.

And so I think that's good feedback. Doug and Jodi, and team you've been tremendously generous in terms of synthesizing a huge amount of information. We realize that there's a lot of work ahead which I appreciate everyone on this Committee and Workgroup volunteering to step forward smartly to meeting that. Walter as you pointed out there's a lot of work between the work that's identified.

John, thank you very much because a large part of this conversation is also guided by your systematically taking inputs from the committee and elsewhere and I appreciate all of you really participating today and all points in between, with that, is there anything that's urgent before we go to public comment? Anything we would like to put on the table?

Then one of the most important parts of this, not the most important part is input from members of the public and with that let me turn to MacKenzie Robertson to invite any participants who would like to speak.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Thanks, John. Operator, can you please open the lines for public comment? And when we're waiting for the lines to be opened anyone in the room that has a public comment please come to the table and I'll just remind everybody that public comments are limited to 3 minutes and there is a clock in the room to help you keep track of your time and I will be notifying when your time is up.

Alan Merritt – Altarum Institute

Also, if you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

MacKenzie Robertson – Office of the National Coordinator

And we do have a public comment in the room so I'll ask you to go ahead and identify yourself.

Thomas R. Bizzaro – Vice President Health Policy & Industry Relations – First DataBank

My name is Tom Bizzaro I'm Vice President of Health Policy and Industry Relations for First DataBank. Dr. Halamka mentioned that long-term, post acute care and mental health providers need to be part of exchange. I would assert that if we truly want to manage exchange of health information that addresses medication therapy management, transition of care and medication reconciliation than pharmacies and pharmacists must also be a part of Health Information Exchange. I appreciate the opportunity to comment here and I thank the committee.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Are there any more public comments in the room? Are there any public comments on the phone?

Alan Merritt – Altarum Institute

We have no comments at this time.

MacKenzie Robertson – Office of the National Coordinator

All right, thank you.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI – President & Chief Medical Officer – Hospital Corporation of America

Okay, my thanks to all of you, to members of the public who participated appreciate your engagement and to the ONC staff terrific leadership, thank you for your hard work. Members of the committee thank you for everything that you do. We stand adjourned.