



HIT Standards Committee Implementation, Certification and Testing Workgroup Final Transcript June 30, 2015

Presentation

Operator

All lines are now bridged.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Implementation, Certification and Testing Workgroup. This is the last meeting of this workgroup. This will be a public call; there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Cris Ross? Liz Johnson?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hi, I'm here.

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

Yay, Cris; okay, good.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I could not get to the operator but I'm here.

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

We heard that was...so thank you. Liz Johnson? Andrey Ostrovsky? Danny Rosenthal? David Kates?

David Kates – Director of Interoperability – The Advisory Board Company

Here.

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

Hi, David. John Travis?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Here.

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

Hi, John. Kevin Brady? Kyle Meadors? Rick Moore? Sarah Corley?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Here.

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

Hi, Sarah. Steve Waldren?

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Here.

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

Hi, Steve. Udayan Mandavia?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare

Here.

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

Hi. And Zabrina Gonzaga? Anyone...I'm sorry, Scott Purnell-Saunders from ONC?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Here.

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

Hi, Scott. Anyone else from ONC on the line?

Mazen Yacoub, MBA – Healthcare Management Consultant

Hi, Mazen Yacoub.

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

Hi, Mazen.

Mazen Yacoub, MBA – Healthcare Management Consultant

Hi.

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

And with that, I'll turn it back to you Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks Michelle. I'm sorry everybody for showing up here at the very last minute. I just literally couldn't get past the operator. So we have one discussion here to wrap up the work that we've

been doing so far which is the discussion on the 2015 Edition Draft Test comments. We had a report out, as you all know, to the Standards Committee last week, along with everyone else and we just have a few more items that we want to get through today.

So, Scott had forwarded a deck that I think you all have that we just got a little bit earlier today and Michelle may have already covered this...I'm sorry, arrived yesterday in the afternoon. But I think unless people have comments about last week's meeting or any other thoughts around the work that's behind us and things we need to attend to, I think we should just walk through these slides today and complete our work. So let me just open it up to say is there anyone who wants to comment on our work leading up to the Standards Committee meeting last week or any comments on the meeting from last week? Hearing none, I think then we want to go through the materials provided by Scott.

And Scott, I wonder if we could impose on you to give a description of, you know, these slides seem to represent a lot of the materials we already went through. Can you just describe a little bit about what you want us to do over the next 60-90 minutes to complete our work?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yes, not a problem, Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks Scott.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great. So go to the next slide for me; one more slide. Great; so this slide shows the test procedure assignments that we previously assigned I guess two calls ago and I wanted to give...so I'll verbally walk through and update on what we want to try to cover today versus what was already covered during the last call. So essentially certification criteria (a)(10), which is clinical decision support, was reviewed on 6/17 along with (b)(1) transitions of care, (b)(2) clinical information reconciliation and incorporation, (e)(1) view, download, transmit as well as e-Prescribing, which is (b)(3).

So today we need to cover, I'm starting kind of in numerical order: (b)(6) data portability and Dave Kates is that lead; (c)(1) clinical quality measures record and export and that's John Travis; (g)(6) which is Consolidated CDA creation performance and that's Dave Kates; (a)(19) patient health information capture, that's Sarah Corley and then (a)(2) which is CPOE for laboratories. So I know that's a lot to cover today in a short amount of time, as well as, I'm sorry, the last two on my screen was a little short; (a)(20) which is implantable device list and (g)(7) application access to common clinical data set. So that is 7 to cover pretty quickly so I want to try to get through the conversation as quickly as we can to pass those assignments over to those leads to get those covered and so we can clarify any particular information that is not or was not properly captured on the slides or if any additional clarification need to be added.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay, so why don't we try to do...the quota says we should try to do this in about 10 minutes per topic. Should we jump into the first one, Scott?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yes sir; so that's going to be (b)(6) and I think that's slide 5 or 6 of the slide deck that you guys have. Oh sorry, slide 8. Great; Dave, take it away.

David Kates – Director of Interoperability – The Advisory Board Company

Okay. So I'm refreshing my memory as I talk; so I think on the data portability, the certifica...the feedback from my subgroup was related to sort of the breadth of the documents that were specified in the certification standard. There were some detailed things here that are listed; I don't need to read them all in terms of specific detailed elements and making sure that they're...that the fields that are specified for the different document templates are appropriate for the use case that they relate to.

The third bullet on this list, or the third major bullet was just I think a lot of the questions in the industry that we've talked about in the past around CCDs in general and around the certification tests have been, you know, what sort of expectations and what should the testing bodies be...hold the EHRs responsible to in terms of the scope of the data, whether it's for this encounter or whether it's for all time immemorial or whether the certification testing should be silent on that and leave it up to the EHR vendor to stipulate. So what we suggested is that there be a mechanism to control that and not have the certification bodies determine that but that there be clarity in terms of the testing criteria.

And the last point was just the group suggesting that trigger events for the C-CDA include not just when documents are signed when an encounter is complete but also that C-CDAs...that there be a mechanism to generate C-CDAs when new information is attained, even outside of an encounter. So in an ambulatory setting, when lab results or some medication fill information in the future would be identified that that might also be a mechanism to generate a C-CDA so, those were the general thoughts and feedback from the group. Comments, questions, other th...? Great, so I'm keeping you ahead of schedule, Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I'm impressed.

David Kates – Director of Interoperability – The Advisory Board Company

I mean I think generally the theme was that...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Say I...

David Kates – Director of Interoperability – The Advisory Board Company

...go ahead, Sarah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...test the time taken up with some of the others.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, no; yeah, this one was more dotting "I's, crossing T's." I think generally it was...there's a fair degree of experience with this stuff, so it was really just getting some specificity around some of the specific criteria in the test aspects. So I'd say with having captured those comments and feeding that back to ONC and the others that are the audience for this stuff that barring any other suggestions or comments, we move to the next topic.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sounds like a good suggestion; anyone object to us moving on? Thank you, David. That one was like 3 minutes; I'm impressed.

David Kates – Director of Interoperability – The Advisory Board Company

Okay, we'll keep it rolling...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

So we'll set the standard at 3 minutes. Slide 10, please. Great, so this is (c)(1), John Travis, you're up.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

All right; so this is clinical quality measure record and export. I'm kind of opening up at the same time a more detailed kind of word document I have, so one second while I get there, that covers some of the same topical matter. Probably the first point is kind of the general comment I think we've made in some in some other places, so I'm not going to go into that; that's just kind of speaking to the level of the test procedure.

Probably the biggest thing that comes out of this is the fact that record and export are defined under one criterion that I think presumes some things that are in question about whether or not that's an appropriate scope or bundling of the scope of this criterion itself. So the first comment there, the test procedure for capture proposes a vendor entered all data for each and every CQM; a couple of things about that.

I think that that speaks to the need for having some kind of observed testing process that could be done more on a sample basis. So in the 2014 certification process, there was an opportunity to go pre-build before live testing, so certainly not during live testing were we expected to go do direct data entry on everything. And for EHRs that have integrated clinical workflow and quality data capture in production as byproducts of the clinical workflow, we're not going to really make use of an import capability to record data so we need another avenue. So we really are, you know, I think our comment here is more that we hope that by live testing this is not necessary that there can be some process of pre-build that allows us to do enough live to prove the point that we're not dummifying up the data, but that we're not requiring an elongated live testing scenario for entry of data.

The conformance tool, this was a comment from our group that the conformance testing done for CYPRESS is not a guarantee that conformance testing or acceptance testing for validation done by the QualityNet submission process are necessarily going to yield the same result. The file validations don't always result in successful pass for...if you pass CYPRESS you'll also pass QualityNet, so we want to make sure that those are aligned so that an EP or a hospital using the capability here for QRDA that if certified can pretty reliably also be the basis for submission of e-Measures not only for Meaningful Use, but certainly for PQRS or for IQR.

I think the next slide, Scott, I'm trying to remember if there is more commentary here. But maybe, yeah, there we go; that's back to David. So, any comments or questions on that?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

John, this is Cris; I think you touched on it but can we be a little bit more precise in the second bullet than just saying recommend substantial change and instead come up with some language that says what specifically we would want?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, let me go back to that one. So the second bullet of the capture provisions or are you really referring to the first bullet, Cris?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Second bullet on slide 10, the second sentence that says “this is highly inefficient, etcetera.”

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, yeah, I...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Are we recommend...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...what I would recommend is that...and I'll say this and Sarah and David can speak, too. Our experience with the testing that we did in 2014, we were able to do a pre-build...one of two recommendations. We were able to do a pre-build of the data sets that were provided out of the CYPRESS tool and the pre-build involved going through our clinical workflow capabilities to actually enter the data and stage the data that way. And we were able to then reserve for live testing some observed live direct entry that would provide enough of a sample to say, all right, I know you're not contriving a Julia Childs' approach of one that's already done in the oven, that would yield the result to calculate or to provide for a valid export exactly as the test would require.

So we're not looking for a canned, you know, we want...we recognize that we don't want a canned result that's a fait accompli based on nothing that's ever observed by the tester. But one approach would be allow for that pre-build to occur and allow for the live observance of a limited amount of direct entry, and particularly knowing that you're not going to stop with record and export, you're going to go on and test to calculate and e-submission. So it's a little bit of contrivance to just take it in isolation here, but at least to the point of this criteria allow that to happen.

Or what I think Sarah suggested in another context, allow the vendor to take an input data set and go and do conformance testing of the export such that it can be successfully validated and attested to by the vendors own effort, maybe not dependent on live observed testing. The issue is, this one takes a long time if you're going to do it by any means that requires live, direct entry of any extensive amount of data. So I hope that makes sense.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

It does, John, and there's a lot of richness to it. I guess the...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Well let me, yeah, let me summarize it this way more simply; allow for one of two processes. One is very much like 2014 certification, pre-build the test data sets that are provided by CYPRESS with limited live observed direct entry to assure that the vendor's not contriving an already cooked, finished example that's potentially very artificial.

Or allow and trust an approach where the vendor can do pre-build and conformance testing that would prove out against the expected outcome for the use of the test data. So the test data's going to be a controlled input, we don't come up with that on our own, but one would hope there's an opportunity for an attestation-based method, including providing conformance evidence that's run through the very same tool that would be used, if it were proctor overseen, to provide evidence of conformance, based on the test data sets that are...that you start with out of CYPRESS.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Hey John, this is Rick; can I...I think and add to some of what you're getting at here is, it sounds to me like you're looking for a robust laboratory test of the algorithms of the software prior to going live. And then some sort of post go-live attestation by vendor and implementation site that they're following the protocols which were established to contrive the measures that are being reported...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

That's, yeah, that's a fair way to summarize it, taken as go-live meaning the certification...the live testing event.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

When you say live testing event, it doesn't necessarily have to be observed, but somebody has to attest that it occurred.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah...

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Okay.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...and it really is a question of whether or not that necessitates live observed testing for the second option...

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Okay.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...that I was suggesting.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

I mean, because it seems to me that the live testing is a combination of both the vendor's implementation and also the site itself complying with data collection efforts that the vendor proposes are needed to make their system work.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah and I understand that we have to take care that we don't want to give such free rein to the vendors so to speak that a contrivance can result that obfuscates the real capability of the system, for the sake of passing certification.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Right.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

But at the same time, we don't want to make this a...

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Too cumbersome, yup.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah. It's already tedious by saying, you know, allow us to do pre-build. We already know we're in for a tedious exercise, we just don't want to have to have the tedium of doing it live and observed, watch me enter the required data sets for all the quality measures. That's untenable.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Yeah, that makes sense.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

And, those of us who are an integrated EHR, we're going to find no utility for an import of a QRDA file as a starting point.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

At a live site.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Well, or for a vendor...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

For anything.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, we're not a data warehouse; we're an integrated clinical system that would originate the data. So record to us is create the medical record entry by the same process that would occur in a production scenario. We are not out to write throw-away software to import a QRDA as an integrated clinical EHR because we don't do that in a live environment, so don't...please don't make us have to do a contrivance to...just for the sake of testing. We're not Quantros or Midas or Premier, we're Millennium PowerChart just...Sarah...reflect for her situation.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Sure. But you should be able to pull in CCD and do it.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

The test files aren't provided at this point...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah but a CCD isn't anywhere near enough information...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...to calculate a quality measure...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yes, exactly.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...that have exclusions and all kinds of...

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Gotcha.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...requirements for numbers of visits in time periods and types of visits.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Gotcha.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

We have...so, so there's a significant amount of effort in the pre-build and while we don't love it, we understand it and its necessity. We don't want to do it as live, observed processes because it would take tens of hours, but we, at the same time, we understand the need to make sure that's not a contrivance that we're just writing scripting to go populate data. We offer as alternative though that there could be a vendor attestation as to the process by which we do our recording functions and then let the evidence be in the conformance test of the output necessary for export. And that could be based on, I think you actually highlighted something a little bit different than I might have been getting at in what I said, but being able to...the vendor doesn't have to be the one submitting the files for validation; that could be a proctor-driven activity that doesn't need to be a live, observed activity, that could be through a process of file upload that is then subject to independent validation through the conformance tool.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So you had two modes that work, one is provision of data roughly and the other is attestation and you're saying for a vendor like you or Sarah speaking for NextGen, the attestation method works. For whom would the sample, concise data set model work?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

As an import of QRDA, which I think is the case...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...somebody who is a data warehouse and not to cite them in any particular way, but vendors like Quantros or Midas or Premier might be of that model, or something that a large health system might have developed as their own capability they were used to using for IQR and for core measures for Joint Commission. And it's just what they use and they'll go out and seek self-certification.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Seems sensible. Any other...does anyone disagree with the recommendation as John puts it? And if not, Scott, do you have enough to put that in a concise recommendation?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah, we'll work on it; because it kind of went back and forth a couple of times, but I think we can get it together. So we'll talk about next steps once we get through everything.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. All right, any other comments on this topic? All right; Scott, can you take us to the next one?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great, next slide should be (g)(6), Dave Kates.

David Kates – Director of Interoperability – The Advisory Board Company

Okay, so it's up to me to get us back on track time-wise...

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

You've got 30 seconds.

David Kates – Director of Interoperability – The Advisory Board Company

Okay, 30 seconds. I actually think there are two main themes to this, I'm looking back to my notes; yeah, they're actually consistent with the two bullets here. So one was, and I'll just leave it for discussion, the certification requirements stipulate the C-CDA Version 2 or...which at this point is a DSTU, Draft Standard for Trial Use. And so much discussion and I think bottom line recommendation is that while Version 2 has a lot of benefits and merits that we should err on the side of conservative and widely adopted Version 1 stuff. That's the first recommendation.

Number 2 is the number of document templates that are stipulated in the C-CDA requirement of (g)(6) and it's a much larger list than was required for Meaningful Use Stage 2 and...which isn't inherently bad, but that not all of those use cases are relevant all of the...the use cases as they relate to the document templates are relevant to the typical use cases for the...where the EHRs are deployed. So, I'm looking through my notes, but I think...I mean at a minimum, it still should include the progress note and the discharge summary...excuse me, the yeah, discharge summary, progress note, and progress note is new, and the transition of care, which is the referral use case.

So we went to the far end of the pendulum and just said, let's keep the document templates to just those three use cases. There...I don't have the regs in front of me right now, but they had a large list of those so we can have some discussion with this group, with the larger group here if there are others that we think warrant being included and that will give me time to look what the other ones were mentioned in the regulations. But those are the three that we recommended. That's my report out, I'll go back and look at...so what we're suggesting is that we limit it to CCD, so continuity of care document for transitions of care, discharge summary and progress note.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right. Any comments on limiting this to three template types? I don't want to put you on the spot Steve Waldren, but I know in the past you've spent some time thinking about templates like this, so if you had any comments it would be potentially useful.

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Yeah and I just think there's probably not much to add in at this time. I think the templates are going to be a challenge moving forward, but I don't think there's any better option that's laid out on the table today.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Cris, this is John; I just might make one comment. It may be admittedly more on the criteria, but it could be relevant to the test procedure and I even want to say, Sarah you might have brought

this up in our last call when we were talking about something related to the use of the C-CDA and that is relative to the templates. Test procedure maybe should tier the document templates to those that are relevant to the definition of CEHRT and then those that are only relevant to the definition of CHIT that are beyond the scope of Meaningful Use and not required for actual use.

Again, that's probably more effectively aimed at the...as public comment; believe me, we made it on the 2015 Criteria Edition NPRM but, it's one that I think we offer here as well as food for thought to probably say a different way the Dave, they prioritize. First, the vendor ought to be able to test what they want to test for perhaps, but don't require all the ones that are beyond scope of what is actually required for CEHRT.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah and the ones in the criteria, now that I've pulled it back up; there's the CCD, there's the progress note and the discharge summary. The other ones that we omitted were consultation notes, H&Ps and transfer summaries.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Um hmm. So the argument is exclude the other types at this point.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah for the minimum necessary requirement that...for certification of EHRs that we stick with...we expand from just CCD, which was MU2 to include discharge summary and progress note.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

But discharge summary only in the hospital setting.

David Kates – Director of Interoperability – The Advisory Board Company

Only for inpatient, yeah; that one just is conditional on inpatient.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

The idea here is that, you know, every time you add requirements that everyone has to have everything, you're increasing the cost where the vendor's clients might not need or want that functionality, but you're increasing the cost to them. And therefore, we should only have the minimum necessary that's required for attestation for Meaningful Use on the part of the users and purchasers of these systems and the market should determine based on their needs which other templates a vendor should support.

David Kates – Director of Interoperability – The Advisory Board Company

Well stated.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup. And so I guess, I don't want to delay us but...this is Cris; the one comment I would make is I think we might want to...maybe this is overkill. But it would be a good thing if the industry at least evaluated the pathway by which we develop multiple templates where a template had a particular use so that as we send and receive C-CDAs that have a template for a particular purpose, that they're more easy to consume, that physicians can actually do something with them, etcetera, etcetera. And I'm wondering if we may want to comment in some fashion that it might make sense for the industry to develop additional templates but that we believe for certification purposes, we ought to focus on these three as being common, non-burdensome and helping advance the state of the art.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, I'm happy to help put some language like that just suggesting that the SDOs or the relevant organizations identify those so that when EHRs implement these to meet use cases that the market demands that there be an established standard, etcetera. And just leave it to that rather than to the certification process.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's exactly what I'm looking for David, just...

David Kates – Director of Interoperability – The Advisory Board Company

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...trying to be cognizant of the critique that we've been inattentive to interoperability requirements and feels like we should speak to it. So, I'll stick with that; thank you. Any other comments on this one? All right, we're making good time. Scott, drive onwards.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Great. Next slide, (a)(19); Sarah, you're up.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

All right, well I'll try and keep us on time but the slides have really kind of compressed what I said so I want to go over a little bit more detail than is on the slide. So the first requirement was to label a document and the question was whether this is labeling, because the mention was advanced directives and birth plans. And it also mentions recording them, even though it's talking about patient health information capture.

So we were asking for clarification about whether this is health information that's being created externally by the patient or if it's information that's completed within the EHR by healthcare providers or whether it's both because it...the wording and the titling makes it confused. And then the next question was a request for clarification as to whether there was just a sub-type of information that needed to be labeled or if every piece of documentation needed to support having a label because as I say, the test lab verification used the examples of a birth plan and an advanced directive. I'm assuming this is so that you can more easily find these documents within the, you know, whatever organizational structure the electronic health record has.

And so then I also asked for clarification that there...that many methods would be acceptable because you might title the document, you might use a name template, you might put it in a category, you might, you know, so some information...over, so we'd want clarification that this is not a prescriptive method of labeling it.

The next requirement was that the user can access the document using a link to an Internet site...I thought we talked about this last time, maybe I talked about it elsewhere. It...we asked that the testers provide a URL to such a site because it would be very unrealistic for a patient to be storing their information in an unprotected web link area. And if it's expected to be somewhere that's password protected, there's no information as to requirements for secondary authentication. So we need some expectations on how the testing would be provided there.

The next requirement was that the user provide a narrative that describes the location of documents. So...and the tester was to verify that a user can reference a location of a document

by providing health narrative information. Again we were just asking for clarification that this could be free text anywhere or did it have to...or was there an intent that this be more prescriptive?

Finally the...there was a...there's a step that requires that the patient can provide health information from multiple sources directly and electronically to the health IT module and that it can be integrated into the patient record by the user. So we asked for clarification that the document, what they meant by integrated, whether that meant that these are being pulled in as images or as PDFs or whether the intention is that they should be pulled in as structured content. And we wanted clarification whether vendors were expected to support all mentioned methods of sending data such as mobile phones or tablets because that's certainly not a requirement for Meaningful Use that physicians be able to...that patients be able to use any device to interact with a patient portal and would be a big expansion of scope of the portal requirement.

And then it wasn't clear whether these...what we had expected from reading the narrative is that this was a requirement so that patients can do online surveys, but it's not clarifying when they talk about sending it whether this is talking about through non-secure e-mail or only using the portal or only using some secure messaging. So there's a lot more details that need to be provided and clarifications here for this requirement.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Sarah, before we do comment, that's really helpful. Before we do comments, do you want to amend this to represent what you just described? I think you said that this is a little bit constrained compared to what...to your broader feedback.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, well I had, as you could tell, I had my...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...four pages of comments. I did submit those comments publically, so they are all available to ONC. But I know you've sort of just constrained us to be, you know, shorter but the problem is that there's about six different steps that are specified and this doesn't identify which of the steps I was talking about. So...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah. I think that we...if there's support for your comments amongst our workgroup, which I think there is, I think we should take the time to add additional comments. I thought your comments were good; I don't have anything to disagree with. So with that in mind, I think we do want to expand these comments as appropriate. Do other people have comments on Sarah's description? I think you sold us all, Sarah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Good.

David Kates – Director of Interoperability – The Advisory Board Company

Umm.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So let's see if we can extend the commentary here. I thought the things that you added were important and if we have to go to a second or third page, that's fine.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah thanks, Sarah. We'll expand that definitely based on what was discussed today.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks, Scott. Can you take us to the next one?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Not a problem. Next slide is going to be (a)(2), CPOE; Sarah, you're back up.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

All righty; this should be a little bit shorter. The first requirement is for a user recording, changing or accepting an order-able test based on the receiving laboratories electronic directory of services. And so my comments about these and then the next requirement was that you be able to receive and incorporate these updated laboratory order compendiums, electronic order compendiums.

The problem is, of course, that the commercial labs are not providing electronic directory of services following the standards mentioned for incorporation into our products. So my comment had to do with that, well first that it's premature to do so, but to avoid the problem that we've seen before where vendors are forced to develop code that they can't then use with their client base. That we work with the major commercial lab vendors as they develop this functionality so that the testing could be done with a real world compendium.

So I had discussions with Quest, who does plan to support this. LabCorp says they are not developing...starting development until it's a finalized requirement and standards are final; so, the request would be that we work with the commercial lab that is supporting this so that what would be tested would actually work and could be used...could actually be sold to our clients. So as always, you know, when you're using a draft standard, our recommendation is that they not be required until the standard is mature and not. But if this requirement stays in, then we need to actually have the testing tools be developed with a real world, lab vendor.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. Any comments? Seems quite practical and straightforward; if there aren't any other comments, let's move on to the next one. Scott?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Sorry about that; next slide, (a)(20), Dave Kates, implantable device list.

David Kates – Director of Interoperability – The Advisory Board Company

And I don't need to invite Sarah to weigh in here, but I will invite all...everyone to weigh in here. So...I'm pulling up my notes as we talk but as shown on the screen here, I mean I think the high level feedback was just to reconfirm that the information that's stipulated in the certification requirement is that that data is readily available from the implantable devices. So, it's sort of a conditional comment because I'm not...our group wasn't intimately familiar with what the state

of the art is in terms of this data widely being available from the UDI and the implantable devices. But that was really the only comment that otherwise good, bad or indifferent about whether this requirement's there. We felt like the test criteria were consistent with the requirements that were in the regulations.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, this is a case where we certainly want to see the test steps and understand which devices because not all devices are currently required to have a unique identifier. That's a phase in so I'm assuming the implantable ones I believe that they are required where some of the other devices are not, but we definitely want that specified and understand what the test methods were and the expectation on how there could be parsed.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. Any other comments?

David Kates – Director of Interoperability – The Advisory Board Company

I mean the only other comment that we made, but it was more for discussion; I think what's in there is sufficient was just to what extent we felt like the EHR should have any validity checking or sanity checking on the data that's coming from those devices, but I mean I...having said that, I would say that's going to be driven by market requirements and that it can be differentiators for the product side wow. It's certainly an interesting topic, I don't know that it's something that we're looking for the certifying bodies to step into, it would just open a can of worms. But, it is an area that might come up so we commented then stayed expressly silent on the topic, having raised the issue.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That always make me wonder when does the FDA regulations and testing requirements come in play.

David Kates – Director of Interoperability – The Advisory Board Company

But that...wouldn't that fall into the...yeah, I mean, to me that falls onto the devices. The devices then ensure that the data those are reporting are accurate and not rely on the downstream systems to validity check it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Exactly, it ought to be able to take in the type of data but not actually deal with the validity.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah. Okay. Good commentary. Anything that anyone wants to add?

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PP, CISM – Chief Information Officer – National Committee for Quality Assurance

Additionally a good API would have validation checking inherently built in, but...

David Kates – Director of Interoperability – The Advisory Board Company

Exactly.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

...that's what should occur.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, yeah. Okay.

David Kates – Director of Interoperability – The Advisory Board Company

Made a comment on, I can't remember whether it was my group or another group, but the patient entered data then to the extent that you're getting those types of biometric data through other mechanisms involving human beings and things, then you're going to need that logic anyways, but now we're into product design, so...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

David Kates – Director of Interoperability – The Advisory Board Company

...we'll pull back up.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Nothing like product development via regulation...okay. Any other comments? If not, we'll take it with those clarifications. I think we have two left Scott, if I counted right.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

One.

David Kates – Director of Interoperability – The Advisory Board Company

(g)(7), last one.

M

Dave it's you.

David Kates – Director of Interoperability – The Advisory Board Company

It is me. And this one's my favorite topic. Hold on, I'm pulling up the criteria. So, this is the requirement that EMR...EHRs be tested to demonstrate that they can expose through a standard API the MU common clinical data set. And the bottom line here is that there's a little chicken and an egg going on and so that our subgroup and me personally and my company certainly applaud the requirement that these data be exposed via an API and that the testing I think stipulates clearly the mechanism.

But the absence of specifying a particular API standard, like staying silent on HL7 FHIR as "the standard" and whether it's exposed via XML, RESTful or via JSON adds, I mean, it's back to some conversations we've had within this workgroup for...since the inception of if these are all "ors," then it becomes an "and" to the EHR vendor. So, in the absen...the test criteria are fine, they are consistent with the regulations but it's...the commentary is that we should bite the bullet and stipulate that HL7 FHIR and even if it's XML and JSON, that we be explicit about that otherwise I'm not even sure how you test it. And it certainly diminishes the value to the industry if it's just an API and every vendor can have their own proprietary API and satisfy this requirement.

Then the other comments, then I'll open it up to discussion is, you have some recommendations about having automated test tools and test fixtures in place, be it NIST or otherwise, that would allow vendors to dry run their products in advance of the testing...the formal testing activities themselves, just to get some assurance that they have followed the guidelines and are going to get through the certification process. I guess that's it, I mean, the last comment ties back to the first that if there's not a standard API and it's the Wild West then there needs to be some mechanism to define how the API definition is going to be published so that it can be consumed by third party applications. Full stop.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right. So this is a hot topic then we're coming to an end.

David Kates – Director of Interoperability – The Advisory Board Company

Yes.

M

That's a big deal right here, yes.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I mean, can you imagine how this is going to be tested? Is the testing lab going to create their own, you know, their own tools that utilize the API for every vendor they certify? That could be extremely expensive.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah and pass/fail criteria become pretty nebulous. I mean, basically it's sort of...it's an art instead of a science, you just have to...the, I guess the system under test would have to stipulate how the data's presented. It would almost have to be presented...exposed through the API through a fixed test tool that the vendor provides or like some human-readable or printable document that can be reviewed and eyeball tested to make sure it's compliant with whatever the spec...whatever, it's just it's a bit ridiculous.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I mean if this...

David Kates – Director of Interoperability – The Advisory Board Company

And I...go ahead, I'm sorry.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No, go.

David Kates – Director of Interoperability – The Advisory Board Company

No, no, no, I was going to say and all, I mean, we can make all sorts of cynical comments; I'm hoping, I'm the eternal optimist, I'm hoping that there's a timing sequencing thing here where much like my earlier comments about using the DSTU version of the C-CDA was inappropriate, that right now FHIR is in a DSTU status. So, hopefully over the comment period in the next few months, I mean unfortunately it's probably not going to get balloted, FHIR's not going to get balloted but hopefully within this calendar year it will be, so maybe there's a mechanism by which...I mean, I think all the forces are moving towards a version of FHIR, particularly within the confines of the MU data set, which was the efforts of the Argonaut Project and some industry led initiatives to really get that rapidly matured. So, I think...I'm hoping it's just a timing thing so I'm really not of the belief that we're just going to...that the regs are going to stay that

it's just an API. But, nonetheless, the regs are the regs so we've got to make sure that that's somehow codified.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So we're a little bit in a tough place with consensus that we want standard APIs to emerge over time; the question is whether a certification process is the best way to do that or...there several ways to do that.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

And you know I think there's a couple of things; one, is certification the right way is the first one. The second is that we know that everybody's enamored of FHIR, but it's...again it's a draft standard and so they decided, unlike say the lab, which is also a draft standard, that they wouldn't require that we use a draft standard that we could use anything which is just basically not testable.

I would suggest that we've made it clear that APIs are desired and many vendors already have APIs for other things anyway, you know, just make it clear that the direction that everyone is looking towards is to support FHIR and that's the goal and not, you know. Right now if you're going to have any requirement for certifying an API, it should probably be attestation right now because there's just no other way that you're going to...that this can be tested well.

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

This is Steve and maybe a naïve comment but, so if a vendor is creating an API and the intent is that the API be used that they would create their own kind of test harness, their own kind of client side testing to verify that the API is working. So in regards to that com...Sarah's comment about attestation could it not be that there's attestation at the actual client, you know, that there was a test client used to test that the API works and that the...that it represents the totality of the common clinical data set?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well you know, I mean, I'd say right now most of the APIs that exist don't have this common clinical data set because the APIs have been put in to support you know a particular function or need that the client of that vendor had asked for and some other vendor had come up with other than the one selling the EHR. So, I'm sure that many APIs that are already developed include many of those data elements, but they're certainly not going to include all of them.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Right, so Sarah, I agree...this is Rick. I think what I'm hearing you say is that, and I think others are agreeing, it would be probably untenable for us to require, or for ONC to require, every API be tested but that every API out there should meet some standards and that should be the test. But that's not necessarily an automated test, right? We're saying that standards should be published and each API should meet that standard.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well not, you know, I mean are you going to take away the existing APIs? No.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Well not take them away but it sounds like there should either be a, again to your point, where they meet the need to transfer or meet the objectives of MU; those APIs should then come into standards, they'd have to. So that's a good point.

David Kates – Director of Interoperability – The Advisory Board Company

Well, I actually don't think...well, I won't speak for Sarah or what she meant, but I don't think that's right in the sense that what we're saying is that vendors may create proprietary standards, they may expose APIs for a variety of reasons to meet business needs and to meet their customer needs. That what we're saying is as an industry that we ought to have all EHRs have a defined API that provides this common clinical data set so there is one way for any App or system to be able to go and find out meds, allergies, problems; the things that are in the common clinical data set. It's not to constrain and have some certifying process for every API you could ever imagine or develop, but instead that there be a small subset of APIs or a single API that's consistent.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

...for the meaningful use objectives or...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

...clinical common data set. I gotcha, that's what I was really thinking, yes.

David Kates – Director of Interoperability – The Advisory Board Company

Okay.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Not every API, I totally understand.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah. Okay.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

That's untenable as well.

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

This is Steve, I mean I get a little concerned when we talk about one of anything, because I still struggle...the rail system to see anything that we have one of anything, but I agree with you David that that would be where we would want to go. But I think there isn't a standard out there, as we know that FHIR hasn't been decided, so there's not one that we can pick. So we don't have that option.

I guess my thinking is that even if it's every vendor created their own proprietary API for this common set of data, it still moves the market forward in the fact that it exposes that common data set to third parties to be able to build applications and to do data extraction and bidirectional exchange if the API supports that as well. And it's not the best, but at least I could see small startups saying, well it's worth it to, you know, connect to NextGen and connect to Cerner and connect to EPIC and create proprietary clients for each individual one because there's value in doing that today. And I think that the market would continue to gravitate towards one or just a couple standards as we move forward. But I just think there's not one, so I don't think we have that option today.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, I mean, right now I...my point is that I think that we should wait until FHIR is no longer a draft standard. But if we're going to go ahead and require the APIs for Meaningful Use, which means that vendors need to have it now for certification that have the core clinical data set, I'm just suggesting that attestation is probably going to be...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...a more efficient method to do this rather than asking, you know, testing labs to come up with their own application to take advantage of the API.

David Kates – Director of Interoperability – The Advisory Board Company

Yup, yeah, I think that's consistent with your comment Steve that while the des...it would be desirable if there was one and that we had...we were at a point where we could stipulate that, you know, absent that, it's untenable to test it and we should just rely on self-attestation that the EHRs will be required and they'll be a mechanism to demonstrate that and to hold them accountable. But that the feasibility of testing it's just not realistic. So, to your point Steve, I mean that until it's a perfect world and there is one that for...in the current state that we instead approach it as a self-attestation.

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

This is Steve; I think I would kind of support that. I was trying to do something a little bit more than that, but one question I have is, so the eligible professionals and eligible hospitals are...have to have the opportunity to be audited should CMS decide that's the case. Is there an audit requirement from or availability I guess, not really a requirement from ONC to if they hear from the marketplace that it doesn't appear that the attestation was correct to go and audit the...?

David Kates – Director of Interoperability – The Advisory Board Company

I'll let ONC comment; my understanding is there is, I mean, there's a dispute process that a customer of an EMR can use if anything...any misrepresentations in any of the certification, including any attestations.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah, we have a...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

But remember, there's no guarantee that whatever cool tool you come up with that the vendor's going to allow you to have access to their data if they don't feel that you're secure enough, etcetera. Because there's a lot of security risk involved in exposing your database to outside tools and...

David Kates – Director of Interoperability – The Advisory Board Company

This is the fun conversation but, yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well I mean it's...

David Kates – Director of Interoperability – The Advisory Board Company

No, no, no...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...not, so, you know, I mean Apple doesn't let everybody that builds an App go on the iTunes Store, you know.

David Kates – Director of Interoperability – The Advisory Board Company

Yup.

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

No, but I think in the audit process that the onus then becomes back onto the vendor to demonstrate that they actually do that, they have that capability and that it's a security issue or it's their client that's not implementing it correct...whatever the issue is...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well the meaningful use requirement is that they don't have to use an API, you know, they can use the regular tools that already existed for Meaningful Use Stage 2...

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

No, I understand that...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...or they can use an API. If they use an API, since there's no standard that has to be followed, then there shouldn't be an issue of them failing an audit because, you know, they're going to use an API.

David Kates – Director of Interoperability – The Advisory Board Company

No but I...

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Well this is Steve and I'm not saying that they're failing an audit, I'm just saying that there would be an audit. So let's say we have an unscrupulous vendor that just says, okay I'm going to attest to this and I'm going to represent, you know, 70% of the common data set stuff. And then we get into the marketplace and that other 30% is desperately needed and then there's ability for

ONC to go and look and say, well now you've got to demonstrate to us and actually show that you were true in your attestation.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Oh...yeah I mean you can do that but what I'm saying is it's not, you know, on the end user if the vendor doesn't say we're supporting this particular tool that works on our API, you shouldn't expect that any particular tool is going to work, right? Because that's...

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

But yet I...

David Kates – Director of Interoperability – The Advisory Board Company

So Cris...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...capability...

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Absolutely. Absolutely. I think we're all saying the same thing.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, so what I...if...I'll let you take back control Cris, but if...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think Scott...

David Kates – Director of Interoperability – The Advisory Board Company

...if the consensus as a group which I'm hearing is, or let me try and paraphrase the consensus of the group that we would recommend that in the absence of a common standard that we believe self-attestation is the more appropriate mechanism for certification on this topic and just re-state the fact that, you know, reconfirming that if a vendor mis...doesn't represent...doesn't actually provide those services...those APIs that they attested to, that, as always, their customer has the mechanism to dispute that or whatever the right word is, to make...to go back and get that product decertified or whatever.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Yeah David I think what supports that notion is the whole concept of information blocking and that pathway to...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, exactly.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

...resolve that; so I think that reinforces the notion of self-attestation, possibly.

David Kates – Director of Interoperability – The Advisory Board Company

But if that...if the recommendation of self-attestation with those other comments which are I'll more artfully paraphrase is the consensus of the group, I can work to reframe our recommendations along those lines.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

David, I think that makes sense...this is Cris. I would maybe start, if this is a friendly amendment, right, if not, push back. Something along the lines that we believe that the development of APIs will advance healthcare interoperability and care and that in every instance where APIs develop, it's usually a combination of market forces and either a convening standards organization or a certification group.

And that our comments are intended to be supportive of the idea of development of an API ecosystem if you will, but that we believe that certification ought to take only a limited role in the development of those APIs. Therefore the recommendations are, and then as you described them. I believe we need to be aspirational around the idea that APIs will help with increase of interoperability and that we would want to make some comments about the role of certification as part of a number of forces that will move that forward. I know that was...

David Kates – Director of Interoperability – The Advisory Board Company

No, no, that was great; I actually took some good notes and I think I captured your thoughts and I accept that as a friendly amendment; I think that's the right way to frame it and we'll offer that back to ONC and to the group.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

What do other people think? Either its complete consensus or we've worn everyone out with...

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians

Both.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Much more consensus.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Good to go.

David Kates – Director of Interoperability – The Advisory Board Company

Perfect, thank you.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, I think we're done a little bit ahead of time. Are there any other comments or requests before we go to public comment?

David Kates – Director of Interoperability – The Advisory Board Company

My only comment with our parting meeting here is thanking you and Liz and the ONC folks for the productive work that the group has done. So...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well everybody knows this is the best workgroup, you know.

David Kates – Director of Interoperability – The Advisory Board Company

Exactly.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

The most productive one, that's for sure.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

And enjoyable.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Let me say the same thing; thanks for everybody who's put in an enormous amount of time and effort in this and particularly David, John and Sarah in alphabetic order as best I can do it, as well as everybody else. But the three of you have really done a great job convening small workgroups and pushing us forward and everyone has made important contributions...I know that we will have chances to work on this more in the future. And...

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

Yes, I just want to echo the thanks and say that more than likely there'll be separate task forces for the three items contained in the title of this workgroup, so implementation, certification and testing and I'm sure that we'll be tapping into all of you in your different areas of expertise. So, thank you for your contributions and hopefully you'll continue to want to serve. And if you do want to, you could let me know or you could update your application in the FACA database. Sorry, for interrupting.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No, thank you. Thanks.

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

So are we ready for public comment? I know we do have a public comment from David Tao.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay.

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

But operator, can you please open the lines?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

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

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

David Tao? As a reminder, you have 3 minutes. Please go ahead.

David Tao, MS, DSc – Technical Advisor – ICSA Labs

Thank you. This is David Tao from ICSA Labs. It's difficult in this set of comments on test procedures to avoid asking whether the certification criteria itself is what it should be. When I was reviewing the test procedures I often wanted to repeat the comments I had made on the ONC NPRM or sometimes I regretted that I hadn't made the comments earlier, before the deadline for the NPRM. And it seems like several of this workgroup's recommendations are really challenging what's in the NPRM more than the test procedure, so I'm just asking, is it out of scope when you're commenting on the draft test procedures to say that the certification criteria in the NPRM should have been changed. Isn't the test procedure actually obligated to test what the NPRM said?

However, I have a suggestion, perhaps the workgroup could frame some of its comments as follows: Even if the certification criteria were to remain as proposed in the NPRM, we believe that only a subset of its scope should be tested and this is the subset we recommend. That would work, for instance, for the C-CDA limited number of document types suggestion that you made. So, that concludes my comment.

I just wanted to say one more thing, take the opportunity to thank this particular workgroup for the recommendations over its lifetime. I've followed a lot of your meetings and I felt that you've all been very practical and thoughtful. Thanks.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thank you, David. Appreciate the comments. Any other public comments, Michelle?

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

No more public comments.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right. Well, I think with that we will reward everyone for all their hard work with 15 minutes back on your calendars, how about that?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Whoo, hoo, don't spend it all in one place.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

David Kates – Director of Interoperability – The Advisory Board Company

Thanks everyone, 'til we meet again.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Thanks everybody for your time.

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

Thank you all.