HIT Standards Committee
Interoperability Standards Advisory Task Force
Final Transcript
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Presentation

Operator
All lines are bridged with the public.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology
Thanks, LaTonya. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Interoperability Standards Advisory Task Force. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Kim Nolen?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
Hi, Michelle, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Kim. Robert Cothren?

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Yes, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Rim. Anne LeMaistre? Arien Malec? Calvin Beebe?

Calvin Beebe – Technical Specialist – Mayo Clinic
I'm here.

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

Calvin Beebe – Technical Specialist – Mayo Clinic
Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Christopher Hills? Eric Heflin? I believe Eric is on. Janet Campbell?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
LeRoy Jones? Lisa Gallagher?

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Lisa. Paul Merrywell?

Paul Merrywell, MS - Vice President/Chief Information Officer - Mountain States Health Alliance
I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Paul. And Peter Palmer? And from ONC do we have Brett Andriesen?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yes, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Brett. Nona Hall? And Rose-Marie?

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology
I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Anyone else from ONC on the line? Okay, with that I'll turn it back to you Rim and Kim.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thank you, this is Rim Cothren, I'm the Executive Director for the California Association of Health Information Exchanges and will be chairing today's meeting, Kim and I have agreed that we're going to pass the ball back and forth during the upcoming meetings so today is my turn.

Before we get started I just wanted to give a quick chance for introductions to two of our members that were not present at the last meeting but are here today, Lisa Gallagher, do you want to introduce yourself briefly?

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society
Sure, thank you, Lisa Gallagher, Vice President Technology Solutions at HIMSS. I am a member of the Standards Committee and previous Co-Chair of the Transport and Security Standards Workgroup and Chair of the Data Provenance Task Force. So, I have been participating in a number of the Standards Committee's initiatives and happy to be involved in this one. Thank you.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thank you and Paul Merrywell do you want to introduce yourself?

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance
Yes, Paul Merrywell, I'm the Chief Information Officer and Vice President at Mountain States Health Alliance in Johnson City, Tennessee. I've been here about 4.5 years and before that I worked in Mercy. I'm recently thinking I've graduated from the ONC IT Fellows Program which was a very good opportunity I appreciate that. Thanks.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thank you and I don't believe Pete Palmer is with us. Pete you didn't join late did you? Okay.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Hey, just for the record, this is Arien Malec, I joined late. So, I just want to make sure my name is registered.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thank you, Arien. Is there anybody else that wasn't present at our last meeting that wants to introduce themselves?

Calvin Beebe – Technical Specialist – Mayo Clinic
This is Calvin Beebe, I don't know if I introduced at the last meeting.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Okay, Calvin, go ahead.

Calvin Beebe – Technical Specialist – Mayo Clinic
Calvin Beebe from the Mayo Clinic. I'm an employee here for 35 years in IT and I'm a Co-Chair for the Structured Documents Committee at HL7, the home of CDA and Consolidated CDA.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thank you. Anybody else before we move on? All right, hearing silence, why don't we move to slide 3, the draft work plan and I just wanted to remind people of what our plan is moving forward, we have a deadline of August 26th to present our final recommendations to the FACA body. I believe that there has been one additional meeting that has been added to everybody's calendar, everyone should have all of these meetings on their calendars now and as we discussed at our last meeting we have made an adjustment to the plan to move Section I not to today's meeting but to the next meeting so that today we can concentrate a little bit more on the scope of the document, our purpose and the annual update process, something that was originally planned to happen late in our discussions. Before we move on are there any thoughts or any concerns about what our work plan is moving forward?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
This is Eric Heflin, no. No concerns.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Eric. This is a pretty aggressive plan so we're still going to have to move forward smartly. Why don't we go onto the next slide, this is just a reminder our charge is to make final recommendations for the meeting that is coming up in August. So, we don't have a great deal of time before we get there. Why don't we move onto the next slide?

And these are questions that we talked about at our last meeting as well. I want to pause here for a second; I'm not going to read through these but to just see if there are any more thoughts or any questions about the charge that has come to the Task Force before we move on?

I think in particular that first bullet there was quite a bit of discussion at our last meeting concerning that, I think that we're going to have a continuing discussion in the coming meetings about exactly how we characterize standards and implementation specifications as we move forward so I would suggest that people continue to think on that.

There has been some discussion as well and I think we'll find that there are comments as well on what characterizes the best available and we may want to revisit the definition that is in the ISA concerning best available standards. Those two points aren't necessarily unconnected.

And then there are some specific questions that ONC has put to us. I think that we'll probably come up with more questions as we go through the public comments. If there aren't any questions on that let's go onto the next slide.

Part of our discussion last time was specifically around guiding principles that we would use as we moved our discussions forward. Kim was kind enough to start an e-mail thread at least amongst some of us based on her notes coming out of that meeting and these are some of the points that we had come up with as part of that e-mail thread. I do want to discuss these a little bit at the meeting here and Kim and I would like to revisit these as we move forward at each meeting.

As we seek comments I think our expectation is that our guiding principles might evolve over time and that it would make sense for us to revisit these in light of our discussions, but I wanted to start today's meeting or Kim and I wanted to start today's meeting with a quick discussion of these. So, in particular if we look at the first bullet there that we should be qualifying standards based on, and then there is a list of a short number of characteristics here, are there thoughts about what other characteristics we should be looking for, whether these are the appropriate ones, whether these are actually quantifiable in some way that would be useful to us or is there any thoughts about any of the other principles as they are stated here?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
Hey, Rim…

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

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
Is that Arien?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Yes, this is Arien, Kim why don't you go ahead and then maybe I can get in the queue.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
Okay, well, I was actually going to ask you a question Arien because one of the things you had mentioned in the last meeting was something around preconditions and I wasn't sure I fully understood that. Is that like directory services and different things that would need to be available to make that standard work better and is that something we should have in here and define it better?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
That is absolutely a great point. I think what I was referring to in the last meeting was what are the expectations that a user of the standards advisory whether that's a provider or organization asking their vendor to implement the standard or a vendor deciding which standard is compliant and positing that the expectations I think those actors would have is that by picking the standard I know how to implement it and use it in order to get some well-defined result and that is what I was describing as the preconditions.

But, Kim, you're right on in thinking that there is more than just the standard at play. There are infrastructure elements and there are policies for example and value sets that may also be foundational for success of the implementation of the standard.

I was going to ask…I can't see the slides right now, but I was going to ask if we've correlated these against the work that we did in the NwHIN Power Team in terms of the standards maturity and readiness criteria just to reference, you know, previous work.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
This is Rim, I don't think that there's anything that we've done to correlate them now Arien that's a really good suggestion and let's take that off line in between the next two meetings and look at correlating these and see if there are adjustments that we need to make based on that. Brett, do you think that you can circulate those recommendations to the Workgroup following the call?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yes, I'm just making a note to take that down as an action right now.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Great, thanks. Arien, I'd like to come back to your comments, so are you suggesting that one of the things that we might end up wanting to include as we move forward in this document are dependencies for each one of the standards?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
That's correct, that's exactly correct, there may be dependencies in value sets, on directory services, on certificates, trust authority, on policies, on some of the other factors that are necessary in order to make the implementation of the standard successful.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
I think that's an excellent suggestion and thanks for clarifying that. I think that I was one of the people that had advocated taking preconditions out because I didn't understand it, but I think that your point is very well taken. Any other thoughts?

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance
I…

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
I did want to talk a little bit about whether we want to focus on provider needs or be broader than that, sorry, I interrupted, there was a comment?

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance
Yeah, this is Paul Merrywell, hey, I apologize for not being in the last meeting, but on that first bullet it talks about maturity of a standard, I wonder if we shouldn't consider potentially emerging technology, so for example, something that might render a mature standard obsolete in the near term. So, rather than focusing on what we can do now, could we leap forward to a new emerging technology and how do we look at that or how would we prequalify that for example?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
And this is…

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
I…

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I'm sorry, go ahead.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
No go ahead, sorry.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Yes, this is Eric Heflin, to build on that comment a thing that has been weighing on me as well too heavily is what's the adoption process to build on Paul's comment?

So, for example, I think we're all interested in innovation but also trying to find a way to balance that with what is the right point to make a leap towards a new innovative technology, because with all innovation also comes new possibilities of capabilities, proficiencies but also increased risk.

And so I wonder if it is within our scope to also discuss, you know, when a technology might be a candidate for future adoption as well too?

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Kim did you want to…

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Yes, Eric, this is Arien, I completely agree with that and I was just thinking that the word "best" needs to be qualified as or/was and in some cases best might mean battle tested, you know, all the bugs and kinks worked out. We know exactly how to implement it.

In some cases best might be but it does one thing and it's on one level the maturity curve. Best also might mean, you know, in the case for example of FHIR and other kinds of things, right for certain kinds of activities but with advisement that there is some risk and kinks, and work to be done, and more implementation headaches that you'll need to go through in order to get the benefits of that best available standard. So, there is a qualification of best what that is very important.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
This is Eric, I agree and the other comment I would add based on the maturity concept too is I think at least some other bodies, some SDOs in particular have actually identified assessment criteria and take for example when something goes from say, DSTU, Draft Standard for Trial Use, to final text or a full standard, or from final text from trial implementation to final text status and perhaps we could identify that as a briefing that could be also circulated to this Workgroup is a summary of maybe a couple of key standards bodies criteria for assessing when they view something as being mature enough to memorialize it as a final standard as opposed to something that is a draft status.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
That's a good suggestion. I have a question Paul since you raised this issue, it is one of the things that we had talked about off line amongst some of us as to whether we needed to have emerging standards in here. I read your suggestion as potentially we would associate emerging standards with specific best available standards to watch that a replacement for this functionality is perhaps emerging, is that what you're thinking or are you thinking, or is the group thinking more a collection of standards to be watching for the future?

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance
I think potentially as we qualify a standard to move forward with if it has a potential replacement or a potential significant improvement in terms of technology, implementation, whatever that it kind of goes on a watch list so we can very quickly transition to that if and when the time is right.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health
So, this is Anne LeMaistre, just a question though, I'm not disagreeing with what you just said, I think though we want to be sure that innovation can move swiftly and I'm not real clear by doing that are we restricting folks from taking a standard that may really solve a problem and being able to move with it.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Well, this is Eric, that's always something on my mind as well too and I think it ultimately, from my perspective, comes down to a balance and essentially an opportunity cost and risks because as we consider adopting a new standard, you know, there are issues that, you know, we don't even know exist yet at the point when it's adopted until it has gone through a certain level of maturity.

And there is also a potential value of doing that as well too. So, I'm kind of closing this out with a question for the group of, would it make sense for us to try to identify potentially a list of criteria at which point it is prudent to consider adopting a new innovative technology approach.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
This is Arien…

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
And is that…

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
This is Arien, again, I think some of this does exist and Eric we did reference a variety of standards development organizations maturity models in the NwHIN Power Team. I'd also point to the accepted recommendations of the S&I Framework that Stan and I, and a Task Force put together that presents at least some recommendations for emerging standards and what needs to be in place in terms of production use and implementation relative to that.

So, again, Brett, if we could do some work off line and just make sure that information and context is ready. I think some of that thought process has already been done and some of it remains to be done.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
From a scope stand-point can I ask people's opinions about whether we focus on provider needs or we start opening this up to payers or public health facing systems, patients, other use cases?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Well, this is Eric…

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
This is…

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I would actually offer a suggestion we do at least include, you know, patient privacy as in the scope, because I think one emerging barrier to interoperability is indeed that consent and authorization policies are different and there is no interoperability in terms of how to express the patient's preferences and I foresee these will be very valuable for us to initially identify a best or a list of standards that could potentially be used to allow the computable expression and allowing for us to more actively address that hurdle before it becomes even more significant of a barrier to interoperability.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Yeah, this is Arien, in terms of best available standards, again, I think there is a "for what" dimension but I don't see any reason why ONC wouldn't want best available for patient engagement, best available for public health, best available for payer/provider interoperability as being in the scope of best available. I don't see any reason why…in fact I see a lot of reasons why best available should be at least inclusive to the parties that you mentioned, in particular the patient and public health not to say anything negative about payers, but I just think those are the…that's kind of the rank ordering of unmet needs in the system.

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance
I would agree, I think if we begin to look at a small subset of the ecosystem we run the risk of creating more of what we have as somewhat silo'd technology implementations and it needs to be much broader. I think the future needs to be a much broader solution set for as many individual practitioners as would participate in the health information standard.

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health
This is Lee Jones, I agree with that. I think that the collaborative care models around value-based payment, etcetera really involve all parties and so you shouldn't limit it to just one segment.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
All right thanks.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
So one, so Rim one area that is probably not often spoken about that I'm hitting up against right now for an active project is actually Department of Justice standards, as you know, because populations have a large healthcare related components and there is also a prescription drug monitoring component and the Department of Justice has driven some standards around NIEM, National Information Exchange Model, that are actually almost parallel to healthcare standards for example for patient care summary exchange with very similar elements but they're incompatible and so I would love us to find a way for us to actually to include that because the current project I'm involved with where we're doing prescription drug monitoring interoperability, half the standards are being driven by, you know, healthcare and CDA, and the other half are being drive by NIEM and Department of Justice standards which in the two are not interoperable without a translation layer.

So, I think it would be beneficial to all those communities if they potentially could arrive upon or at least we could identify the common standard across both those organizations or efforts.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Eric. There are two other areas that I can think of that have also received some attention as of late, research purposes appears in the interoperability roadmap and we haven't discussed that here at all. I think we at least need to keep in mind whether we're ready to start identifying standards that meet research needs if they are different from others here.

A similar area to Department of Justice is emergency medical services which has a set of standards on their own that aren't completely integrated with the healthcare continuum and although we may think of emergency medical as part of the provider continuum it's usually not integrated yet and there may be a need for us to consider standards there to support that functionality as well.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
This is Eric, I completely agree especially about emergency responders. I was on a call recently with an emergency responder driven organization and they have many challenges one of which is that often they don't know a patient's demographics enough to match them and so the information they capture there at the point of initial care is often insufficient to reconcile a patient record to an EMR or emergency management system.

So, I do agree and it seems like they're indeed in a silo and there should be a way to potentially address that within the scope of this work, I believe that would be beneficial to a large point of initial care for many people.

Christopher J. Hills – DoD/VA Interagency Program Office
This is Chris Hills with the IPO, Arien, I think that was you talking previously. The ONC roadmap seemed like it did really well addressing that area that we were talking about, about the redevelopment, what is the relationship of this document to that roadmap?

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Maybe someone from ONC can speak to that a little better. This is Rim and I can at least tell you what my read on that is, is that the advisory is meant to alert stakeholders of the standards that they should be paying attention to considering implementation of or considering adoption of because they represent the standards that are best suited for specific functions that should eventually lead I think, and I'm going to speak for ONC here, potentially lead to realization of a learning health system as called for in the interoperability roadmap but that this document will remain a separate document that has its own update process and path moving forward.

Brett, do you want to talk a little bit more about how ONC sees the relationship between these two documents or do you have any thoughts there or Chris or anyone else that might be on the phone?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
No, I think your initial analysis is pretty right on. I think, you know, we see these two documents as working really closely together. So, the interoperability roadmap really looking at kind of the longer term and moving us towards the learning health system and the ISA really helping us get there incrementally and looking year after year at what we're able to see as best available in the field on a really annual basis.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
I'm sorry, I've already forgotten who it was that asked that question? Were your thoughts that we might want to explicitly link this document to items in the interoperability roadmap or do you feel that it should have its own independent life?

Christopher J. Hills – DoD/VA Interagency Program Office
Yeah, this is Chris Hills coming from DoD/VA IPO, it may just be good to talk about the relationship between those, you know, within the DoD and VA, IPO we are working to connect those two organizations and those systems together and making the interoperability and we're utilizing leveraging the information out of this advisory as well as the roadmap so that all of our systems can connect and interoperate with the rest of the world. So, that's where we're looking at and actually over in ONC today trying to talk with Chris and Chris, and Brett to connect all of these.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Chris. Kim before we move on from the principles I just wanted…since you kind of drove this effort after our last meeting, is there anything else that you want to make sure we touch on before we move on?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
What about the third bullet because that was something I believe Janet had brought up about what's on the vendor roadmap and we haven't really touched on that and how that may meet the market demands. Did we want to open that up for discussion?

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Sure, there was at least a little discussion, this is Rim, there was at least a little discussion at the last meeting about a desire to perhaps survey vendors to find out what standards vendors were intending to implement and how that fit in with best available standards that were showing up in the advisory. Are there any more thoughts on that point? Thanks, Kim, for bringing it to our attention. Do people think that's a good idea? Do people think that we…responses from others?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Yes, this is Eric, Heflin, I think it's good to the extent that the…regulations do not name something that's in fact actually critical for interoperability, that it indeed would be listed here if not elsewhere to give vendors a single target because I think one of our biggest problems…roadmap issues in terms of evolving standards is lack of, you know, clarity about what is a single target that vendors can all work towards achieving and whatever we can do to help, you know, clarify for them that this is indeed…here are the options and here are the preferred options, would just really benefit the entire industry by giving them a single target to aim for.

So, here maybe there is a good opportunity for us to particularly, at least use some of type of outreach of the vendors asking, you know, what are the gaps assuming we don't have enough information already from the feedback from the vendor's community, which I think we'll be going through as part of the process for this Workgroup or this Task Group, to ask them, you know, what else should be mentioned and what other fragmentation exists that we need to help clarify and give feedback from the community at least on what they need.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
All right, thanks. If we could pause here for just a second I just a got a note that Pete Palmer has actually been on the line during this time but has been having problems with his audio connection. Peter are you with us now?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
He should be on now.

Peter Palmer, CISSP, CPHIMS – Chief Security Officer – MedAllies
Yeah I'm on now, thanks.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
So, Pete, we'd asked other folks that missed our last meeting to introduce themselves briefly, do you want to take just a half a minute and introduce yourself to the rest of the team?

Peter Palmer, CISSP, CPHIMS – Chief Security Officer – MedAllies
Sure, I'd love to. My name is Pete Palmer and I work for MedAllies, I'm the Chief Security Officer and I really look forward to working with this Workgroup. I have participated in other interoperability workgroups and so I think just, you know, carrying on with the work that we've done, you know, moving forward…so I am looking forward to it and I'm also very active with the Kantara Initiative, you know, identify management standards. So, hopefully, I can bring some of that in the area of interoperability to this Workgroup.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Pete and since you were forced to be silent is there anything you wanted to add before we move on with the agenda?

Peter Palmer, CISSP, CPHIMS – Chief Security Officer – MedAllies
No, there isn't, thanks.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
All right, thanks. Brett I think the next thing that was on the agenda if there isn't anything more on principles, I think the next thing on the agenda was to start looking at some of the public comment that we received and I know that your team has put together at least some high-level summary in the slides. Do you want to run through those slides real quickly and then we'll come back and discuss them?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yeah, sure, so I can…I don't know if it makes sense to kind of run through all of the four that we have here or it makes sense to stop and take them individually.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
I'd like…

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Maybe we can at least…go ahead?

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
I was going to suggest unless you think differently since it is just a small number of slides why don't you go through them all so that we get a picture of, you know, an overview of the comments and then we'll come back and we'll address each one.

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
All right, sounds good. So, again, just a reminder these are a review of the written comments that we got from Task Force members based on their review of the overall public comments related to purpose, scope and the annual update process. So, thanks to those that were able to submit them and we're hoping to kind of further refine these and get more input from the group going forward here.

So, related to the ISA purpose, effective healthcare interoperability likely occurs when use cases are well defined, those well-defined use cases guide standard choices, enable to creation of a tightly constrained implementation guides and enable effective testing and validation, and simple process. The overall purpose here was one of our Task Force members, Calvin, I believe created this graphic from another source.

Calvin Beebe – Technical Specialist – Mayo Clinic
Yeah…

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
And then moving…go ahead.

Calvin Beebe – Technical Specialist – Mayo Clinic
I was just going to say, I created the graphic as a way to try to understand some of the comments that were summarized by different groups as to the use of use cases to drive interoperability and I think there are some there in consideration for what they're saying.

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
All right, so let's move onto the next slide here, comments related to the annual update process, acceptance of the annual point in time, assessment of best available standards support for that. An undercurrent of concern that the industry needs stable specifications to establish interoperability as well as a suggestion that given standards stability over time might be expressed by a date range or some other manner.

And then moving forward to just a couple of slides on scope here, some comments related to changing of sequence of presentation to the order as seen here, vocabulary, then data structures, services and transport.

Some comments related to changes requested in notation about standards so identify "new" or "stable" or "level of adoption/maturity" identifying those emerging standards or draft standards for trial use, identifying specific value sets to use.

And then on the final slide, summary here of comments looking at a wider…looking at widening the scope beyond health care to health and preventative medicine, public health, behavioral health, socioeconomic factors. Here you can see different categories administrative and payment oriented, privacy and security, patient ID and patient match, consumer and patient engagement and consumer generated data as well as nursing documentation.

And then the final comment here related to scope is a list of standards in four categories does not ensure interoperability rather it acts as a guide of those standards that are given preference when implementation specifications are defined in support of interoperability.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Well, thank you, Brett, why don't we rewind to slide number seven the one on use cases and we'll open for comment. Are there thoughts about this or in general any of the public comments?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
This is Eric, I actually had a question on this one in particular, the graphic is that intended to enumerate relationships between these three dimensions or is it just intended to illustrate that these are three dimensions of concern?

Calvin Beebe – Technical Specialist – Mayo Clinic
I think the intent of the graphic was a way for me to visualize the potential relationships between whether you have very specific use cases or very general capabilities that are being asked for and what derives from that.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Okay.

Calvin Beebe – Technical Specialist – Mayo Clinic
Do we have tight constraints or lose constraints?
Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
All right…

Calvin Beebe – Technical Specialist – Mayo Clinic
Based on…

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I'm sorry, go ahead?

Calvin Beebe – Technical Specialist – Mayo Clinic
Based on that I think you end up with specifications that either express less or greater optionality and it turns out to really be kind of an interesting burden on the industry if there are lots of optionality.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Okay, well, very good, thank you. I agree that it seems like the work that I'm currently intimately aware of, you know, have definitely the same experience that if we have a loose constraint it is much, much more difficult to achieve interoperability because if nothing else the complexity of the testing is actually exponentially greater each time we have two options instead of one, you know, it's twice as much we have, you know, another option it's four times as much and so on, and that grows exponentially as almost a common problem in terms of just testing. And so whatever we can do to constrain I think definitely equates to increased viability and interoperability.

Ultimately you can probably achieve interoperability even with relaxed constraints and relaxed specifications, but it is much easier I've learned from hard learned experience to first have a more tightly constrained specification and then to relax it as needed to accomplish certain use cases whereas it's extremely difficult to do the reverse where you have a relaxed constraint and then you try to tighten it up later that often can actually prove to be very difficult to impossible.

Calvin Beebe – Technical Specialist – Mayo Clinic
No disagreement.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Well, I…this is Rim, and I have to say that I have some concerns about this concept and it is around well-defined or tightly defined use cases because I think that this can be very limiting to interoperability as well in a way that is not intended.

I think for example specifically about the use case for transitions of care that's written into Meaningful Use that by specifying that it was for a specific use case transitions of care to use Direct to pass care summaries that how it was implemented in many systems is that anything passed other than a care summary was rejected and as a result there are many other capabilities that could easily have been handled but perhaps unintended constraint on…imposed by the use case eliminated those.

And so I tend to favor moving towards perhaps well-defined functionalities as opposed to well-defined use cases as providing a middle ground in capabilities without leading us down a path where it's not testable as Eric was saying. Is that appropriate or Eric do you think that getting away from use cases and trying to constrain functionality is just not a viable option?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I'm trying to keep an open mind on that issue. And a lot of times I reason by analogy and in many cases I look at our healthcare environment nationally or even internationally as having an analogy in terms of other complex system designs.

If you look for example at operating systems, you know, there are the bare metal and on top of that it's what's often called a HAL or Hardware Abstraction Layer and that layer is unique because it is what you speak of it's a system designed to enable capabilities and functionality without necessarily imposing any kind of restriction such as often security restrictions or things like that are not imposed at that layer, but then on top of that layer is where the security restrictions, if you will the clinical use cases, business uses cases, applications and so on can be developed.

And so I think there definitely could be a place for both. I see this being hierarchical Rim where the top of the hierarchy are well-defined and tightly constrained clinical and business use cases and then from the fallout from that is that it will then illustrate a list required functionality.

And I think the order is really critical because if we don't have that exact order what can happen is we could actually have a functionality that's implemented with no corresponding use case or alternatively even worse we could actually have a use case that we need to accomplish, which is I think probably what you're speaking to, where the functionality does not exist.

And so if the use case drives everything then we actually have a way of assessing and measuring the functionalities in lower levels to make sure they're actually adequate, sufficient and frankly that they're not overkill for the intended use cases.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
And I think those are good points Eric and my concern always is that as long as we have a set of use cases they're use cases we're not going to envision and so we're not going to drive all available functionality and so I think you raise a good point that we need to be thinking about things from both ends to make sure that our set is as complete as possible. Thanks.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Great, thank you.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Other thoughts on these comments?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Yeah, this is Arien, this is actually an area where another Standards Committee Workgroup had approved recommendations relating to the notion of orchestration patterns and core composables as a framework for thinking about, as Eric noted, you know, some of the more generalized features of interoperability that can drive a variety of use cases.

I share the concern that too much of a use case approach can lead to stovepipe standards where we do one thing for this thing and one thing for that thing, and one thing for the other thing and what we tried to do in the Architecture Services and APIs Workgroup and, you know, got turned into recommendations to ONC, was think about a framework for looking at layers that were more general for which specific use cases could be implemented, you know, the classic one that we noted was the pluggable App pattern wherein some of the Argonaut and DAF work on FHIR, and the SMART work there is the possibility of implementing a spare set of resource standards and transport and security standards that can then be used for a wide variety of use cases.

As a preference, I do believe that a best available standards approach should seek to implement new use cases in terms of core composables and orchestration patterns that have already been elucidated and adopted.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Brett, can you make a note also to distribute that report to the Task Force?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yes, I've got it.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Any other thoughts on this slide? Why don't we move onto the next one. Brett, I do have a question for you in your analysis of the comments you list here stability over time might be expressed by a date range or some other manner. Was there any more explicit guidance given in the comments there about what date might be identified is that meant to be a date that the standard moved from draft into trial implementation or how long it's been…was there any other guidance there?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
From the public comments not necessarily…guidance, they were kind of a number of recommendations but nothing expressly defining what that was.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Okay. Does anyone have any thoughts about the comments that are listed here?

Calvin Beebe – Technical Specialist – Mayo Clinic
This is Calvin, on the last one I think the interpretation I had when I read through the materials was that they might be looking at the expectation as they're recommended the dates that they might be recommended across or some guidance as to how long they may stay stable or not, but that was the interpretation I had.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
So, Calvin, I'll put you on the spot, does that seem to make sense to you? Is there some way that we might implement something like that?

Calvin Beebe – Technical Specialist – Mayo Clinic
Well, it's an interesting question, change can occur at any time and opportunities and innovation can occur almost at any time so it's a risky thing to say something is going to stay stable for five years and then the next year say "well, we were wrong on that." However, it does give organizations and software development teams an opportunity to know what is likely to change and what is likely not and I think there is a general desire to know that.

So, it may not be that date ranges are the best way to do it, it may be, you know, some kind of general coding strategy where stable and not expected to change in the short-term is the best you can say, I don't know.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
So, this is Eric, I wonder if another good way to express the same concept trying to kind of reverse engineer the actual intent behind this comment, would it be appropriate to perhaps issue a listing that includes an attribute of each standard indicating that standard is considered to be final text or not, or its equivalent, you know, is it a draft or is it the final.

And then for vocabularies I'm kind of questioning whether or not this actually ever would apply given that most vocabularies are periodically maintained and updated, and dynamic in nature.

Calvin Beebe – Technical Specialist – Mayo Clinic
True.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
And perhaps it makes sense to discern between standards that are vocabulary related and ones that are…where the change is probably part of the normal process I would say versus other specifications such as web services interfaces or perhaps content standards where things perhaps are more locked down in general.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Yeah, this is Arien, I'm not sure that that's exactly true, so, Eric I'm thinking about for example XDS where there are quite a number of LOINC oriented vocabulary standards that are associated with successful use of XDS, so I don't think that particular paring works but I do acknowledge that there are some things like purely at the transport layer that are non-vocabulary related and other things where there are more vocabulary dependencies.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I agree with the way you expressed that. So, the XDS perhaps itself is rather stable although that used under the head of XDS in terms of vocabularies is expected to change. So, I agree with that concept.

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

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
The other complexity I often struggle with about this topic is something such as transport and security in particular changes on an hourly basis very literally in many cases overnight the industry will wake up to find that some specifications such as TLS v1.0 was found to be vulnerable or compromised, or is no longer approved for use.

And so the other thing I think we should find a way to work into this is either not being specific allowing for flexibility, allowing for that type of necessary reactionary change to occur or alternatively to have perhaps a list of process accommodating that type of a scenario.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Eric, do you think, this is Rim, do you think that it is possible in advance for the advisory to identify standards that might fall into that category potentially? I mean, your example using the security standard is clearly a vulnerability and security standards might fall into that or do you think that most of the transport related standards would fall into that category and perhaps just a statement to that effect in the advisory is sufficient?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Okay, sorry, my phone wouldn't unmute. Yeah, that's a great question and I'll put some more focused thought into this. The way I did address this at one point was some work done for the CQH was to have an acknowledgement statement saying here is the current target in terms of, in this case, a secure transport but that the door is open for adoption of more advanced standards, essentially closed and open-ended specification, if you will, as opposed to a closed ended specification, which is one way potentially of accommodating this and I do think that the maturity and my concern in this regard is indeed related to security as related to transports and standards such as for example secure e-mail relies on CMS cryptic...syntax, which is a certain set of procedures and algorithms for encrypting the data contained within an e-mail with one or more targets.

And if overnight we find out that this actually has been compromised then how do federal regulations actually accommodate that is the question I think a concern at this point especially if the federal regulations point to a specific say "version" of an underlying standard which is no longer viable for some type of reason such as a vulnerability.

So, my recommendation would be to at least let's leave the door open for accommodating one or more mechanisms as the Workgroup can potentially agree upon.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
All right, thanks. Other thoughts? So, I have a question I locked in on the word "stable" here and as we went through attributes of standards in our principles I'm not sure that stability was necessarily one that we focused on, is this something…do we believe that we're already dealing with stability here? Do we need to be thinking about how often a standard is updated as an indicator of stability? Is there something else we need to add to attributes to address stable?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
You know this is Arien, I think this is actually already addressed by our previous comments that there is a range of…there is "best for what" and in some cases you may choose something that is best for purposes of being innovative or forward looking so used for new and novel approaches like pluggable Apps or forward looking in terms of likely to be a replacement for something that exists at the cost of some instability. And in other cases you are looking for tried and true and been there and done that.

So, it seems to me that stable is an artifact of or an outcome of what flavor of best you are looking for if your definition of best is indeed "I use it, it works, it's well known, it's well understood" you will be looking for highly stable specifications.

If you are looking for solving new approaches, doing pluggable Apps right now or doing patient engagement via APIs you may trade off stability for other attributes that you're seeking.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Another related concept perhaps could be how stable the standard is from deployment to deployment. For example, I think one of our largest issues we're facing today is that some standards by intent were only 80% standards is the common phrase I hear used, that is for example HL7 v2 and earlier versions of Hl7 v2, I think later versions have potentially tried to remediated that, but there, you know, implementation and part of the expense we're seeing, part of the costs and timeframes we're seeing as far as connectivity is the fact that every or most HL7 versions and implementations are different and you can't just drag and drop, and interface from one vendor or one set of vendors to another deployment as a set of vendors, or from ADT feeds from one vendor is very different than an ADT from another vendor.

And so, I think a key consideration should be, you know, how consistent and how stable are those implementations from the vendor and from deployment to deployment and specifically although I'm excited about the possibilities of FHIR that is also one of my concerns is that the core team states repeatedly that it is intended to only be an 80% standard, which means that by definition unless another profile or something is put on top of FHIR every deployment is going to be different and that doesn't get us to where we need to be in terms of national interoperability.

But, I would suggest that one of our criteria include some way of expressing that concept of, you know, how variant are the implementations and that perhaps is an instability.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, other thoughts? Why don't we move onto the next slide, at least some of the comments were directed at the scope and organization of the document. Are there any thoughts about any of these comments?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
So, this is Eric, just one very quick comment that I believe that there should be a use case layer as well perhaps near the beginning to help and then a column to the right of each of the standards indicating which use cases that it is intended to help satisfy but other than that I think the organization was excellent.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Eric. I think that's actually a good suggestion. I think that we ought to, you know, based on our previous conversation we ought to at least be thinking in terms of perhaps cross walking between use cases and functionality as well and we might at least explore the ability to list both of those and make sure that there is functionality that is tied to use cases as well as just driving it through use cases, but Eric, I would agree that identifying at least some potential use cases to make sure that there aren't standards that are orphans.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Very good, thank you. I try to have at least one good idea per call.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Stop it. Are there any other thoughts? I think one of the things that we are going to have to focus on, and I'd ask everybody to give some thought to, is the notation about standards, we've talked a lot about that on the call already some of the ideas and our principles, some of the things that Arien mentioned in our last slide I think are things that we should be thinking about as how the terminologies surrounding how we characterize standards and we ought to, by the time of our final recommendation, come up with a good list of terms and what need that they're trying to express. And I'm thinking in particular about, you know, the comment of new versus stable or level of adoption or maturity that we need to think about terms that we recommend are adopted in the advisory.

Eric, I heard you say that you believe that the organization of the document was good. Are there any other thoughts on organization?

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health
This is Anne…

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
No…

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health
I'm sorry, go ahead.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I was just confirming Rim's comment that it was an accurate recasting.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health
Yes and I was just going to agree that I thought also that the organization was good and I didn't see a need for any major restructure.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
All right, why don't we move onto the next slide. Now we've already talked a little bit about focusing on providers in our principles. I'd like to at least think a little bit about whether there are any other suggestions in the comments that we ought to consider in adjusting scope of the document.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
So, Rim this is…

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society
…

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Probably not our only opportunity to comment on these topics is it? The reason I ask is I'd like to put a little more thought into some of these issues before commenting.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Oh, absolutely not and as I said before I think that at least Kim and my intent was that we would revisit the principles and some of the scope of the document in each one of our meetings because we may adjust our thinking given the time in between these meetings and as we read through the comments and react to the comments. So, absolutely not.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society
This is Lisa Gallagher, with regard to security the Transport and Security Standards Workgroup did provide a recommendation to the Standards Committee on a set of security standards that could be referenced and so that is something maybe the ONC folks could dig up for us to have as part of our review.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, any other thoughts?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
I'm curious too, Rim, would there be a more detailed listing of the comments received by this Workgroup as well for example if all…are very useful as a high-level summary but we also I think maybe in this particular area would be well informed to look at more of the detailed comments received.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
I completely agree with you Eric and Brett maybe you can talk a little bit about what you would see, what we should expect moving forward for getting comments from the analysis that your group is performing?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yes, so for the comments received from the public we did provide to all the Task Force members a listing of all the comments we received in these different categories and in an Excel spreadsheet. We are working on going through that same exercise for Sections I through IV or V as we progress, we are actively trying to get through Section I now so you'll have the whole full body of comments as well as trying to get a summary created of the different comments received from the public in each of those sections.

In terms of what was received by Task Force members, ultimately what's on these slides, I didn't get a whole lot of comments from Task Force members this round so this is almost pretty much verbatim what was received in each of these categories, but if there are…as we get more into topics where there is more detail if there are more detailed comments that are received that we don't include on summary slides we can certainly send those out to the Workgroup for reference as well to get a deeper look into the comments.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
And just for the group reference, this is Kim, I believe Brett you sent out that Excel sheet on Friday around 4:36 p.m. Eastern Time so if y'all want to go back and look there is an Excel sheet that has a lot of more detail of the comments. Is that correct Brett?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yes, that is.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
Is that right one?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
That is correct.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
And then Brett what people should be expecting is that Section I comments would be distributed in a similar format in the coming next couple of days is that your hope?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
That's correct. My hope is to hopefully have it by the end of the week if not early Monday.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Are there any other thoughts on the comments that are listed here on this slide.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
No, just I hope that we would weave into the next version of this the discussion I think near the opening of the call where you had asked for feedback on overall scope. I think we provided some comments there as well.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Yes. I kind of have a question for the group here. The last comment that is listed here is that a list of standards in four categories does not ensure interoperability and that's certainly true. Is there something that we should be recommending to address this issue in the advisory or is this merely something that we need to bear in mind?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation
Yeah, this is Arien, I think I've previously suggested that the standards advisory either needs to…and I think we've gotten at some of these comments in this meeting as well, either needs to point to all of the preconditions for success of the implementation that's the standard implementation, specifications, trust and policy, infrastructure, value sets and the like that are necessary to support interoperability or the ISA needs to in effect have a "your mileage may vary" note that, you know, this is a best available standard for some purpose but we have not yet defined all of the constraints that are sufficient to enable full interoperability, otherwise we run the risk of in either case really violating the expectations that users of the ISA might have.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Thanks, Arien, I actually had that linkage to preconditions and I think that's useful, thanks. Any other thoughts? For those people that did have a chance to look over the detailed comments before today's meeting was there anything else that you saw in the comments that you'd like to bring up that weren't covered in the slides here that Brett prepared?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
No nothing that we haven't already covered, thank you.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Okay, if not Kim just real briefly is there anything else that you've thought of that we should try to cover today? Is there anything that you want to go back to from scope or from principles given today's discussion so far?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
I'm good, thank you.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Okay, then Brett do you want to touch base real quickly on what our next steps are?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
This is Michelle, can we open up for public comment and then go to next steps so that we have time in case somebody has a comment?

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Absolutely, I'm sorry I was getting us out of order, certainly.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
No, no, thank you, Rim. 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
So, Brett if you have any thoughts or next steps while we wait for public comment?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Sure, so there was a slide here you don't need to pull it up necessarily but essentially, there is it, be on the lookout for Section I comments and hopefully summaries to be distributed by some time on Monday.

If you all do have written comments and recommendations based on the comments you are reading if you could get those to me by the end of the day on July 14th we can quickly turn those around into slides in the next day or so and we will be ready to talk about as much of Section I as we can get through at that July 16th meeting.

So, again, be on the lookout for an e-mail from me that will clarify the dates and deadlines here and also have comments from the public attached from Section I.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
And Brett can you remind us your expecting any written comments for the comments that you've already distributed by close of business the end of this week?

Brett Andriesen – Project Officer – Office of the National Coordinator for Health Information Technology
Yes, I hope to have additional written comments about scope, purpose and then annual updated process we can take those until the end of the day Friday.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
All right, thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
And it looks like we have no public comment at this time.

Robert Cothren, PhD, MS, SB – Executive Director – A Cunning Plan, California Association of Health Information Exchanges
Are there any questions about the next steps? If not are there any other comments, anything else anyone wants to discuss before we close today's meeting? Well, given silence then thank you very much, I think we had a good discussion today. Please take a look at, in your inboxes, for the comments that Brett distributed last Friday, get any written comments into him by the close of this week if you can and then look in the coming days, certainly by Monday, for comments on Section I and please make an effort to look through those comments prior to our meeting next week. Thank you all for attending.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.
Thank you, Rim.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health
Thank you.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority
Thanks, everyone.

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

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health
Thanks a lot.

M
Thank you.

M
Thanks, Rim.

M
Bye.