



**HIT Standards Committee  
Interoperability Standards Advisory Task Force  
Final Transcript  
August 10, 2015**

**Presentation**

**Operator**

All lines are now bridged.

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

Thanks Rob. Good morning eve...or 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 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. Robert Cothren?

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

I'm here.

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

Hi, Rim. Kim Nolen?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Hey Michelle, I'm here.

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

Hi, Kim. Anne LeMaistre?

**Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health**

Present.

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

Hi, Anne. Arien Malec? Calvin Beebe? Chris Hills?

**Christopher J. Hills – DoD/VA Interagency Program Office**

I'm here.

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

Hi, Chris.

**Christopher J. Hills – DoD/VA Interagency Program Office**

Hello.

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

Clem McDonald? Eric Heflin? Janet Campbell?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

I'm here.

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

Hi, Janet. Lee 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**

Here.

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

Hi, Paul. Peter Palmer?

**Peter Palmer, CISSP, CPHIMS – Chief Security Officer – MedAllies**

Here.

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

Hi. And from ONC do we have Brett Andriesen?

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Brett is here.

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

Hi, Brett. And Nona Hall?

**Nona Hall, BSN – Chief, Standards Adoption Monitoring & Reporting Division – DoD/VA Interagency Program Office**

I'm here.

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

Hi, Nona. Anyone else from ONC on the line? Okay, I'll turn it back to you Kim and Rim.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Well thank you and good morning or good afternoon, depending on your time zone. Welcome to the next meeting of the Interoperability Standards Advisory Task Force. Let's go on to the agenda. So today we're going to be continuing our discussion of Section II comments. We actually have a relatively short list of comments to get through Section II today, so I would expect us to finish up on that today, so that will be good. Let's go on to the next slide; we've done roll already. The next slide...

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

Hi Rim, Eric Heflin joining late.

**Calvin Beebe – Technical Specialist – Mayo Clinic**

And Calvin Beebe joining late.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Great, thank you. So today is August 10; we're slated to finish up Section II comments today and that's what you find in the slides that were distributed this morning, the comments from Section I and Section II are both included there. Later on this week we'll move on to Section III and IV; both of those are shorter comment sections in a new meeting that was just scheduled this week. If you don't have that additional meeting on your calendars, make sure that you reach out and ask someone to add it to your calendars. Go on to the next slide, please.

We always start all of our meetings with our guiding principles; I'll pause here just a second to see if anyone has any changes or additions they want to make to this. I think we've pretty much settled on what our principles are as we've moved forward so thank you. Let's go on to the next slide. The slides list our purpose and our goals for the task force here. Kim, while this slide is showing, we often do summaries of our past meetings; I think you mentioned at our last meeting your plan was to distribute notes via e-mail so people should be watching for notes of our summary thoughts probably later this week?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yes, I'm going to be working on those this week and probably the weekend, so, I'll send them out in sections, because there are two calls and then this one, so there are actually three calls, so I may do them call by call.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

And I know that we've had a few people that have missed some of the meetings, so it'll be good to get those out. So thank you very much, Kim, for doing that. Kim spends a great deal of time going through the recording for all of these meetings, making notes and really appreciate that Kim. If there aren't any other general comments before we get started, then why don't we go ahead and pick up where we left off last time, which was in Section II in images; I believe that's slide 50 in this deck.

So we had started our discussion of images here; I'm not sure that there is anything more that people wanted to say here, but this is the last set of comments that we ended up with. So, are there any other thoughts concerning digital imaging here? Okay, good. Well let's go on to the next slide then. Our next topic was immunization registry reporting. Are there thoughts on this? I know the last time we talked a little bit about variation across...in public health reporting; I think those comments carry through for this as well, that there is a general thought across the task force here that ONC should work to try to add some uniformity to the standards across states so there's less variability. Are there any more specific thoughts about immunization?

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

This is Eric. To kind of drill down a little bit for a second, specifically what I was suggesting on the last call is not so much that ONC provide clarity on that as much as the ONC really convene the stakeholders with a stake in this process and then actually to bring all those together to jointly agree as a community around what would be a target or hopefully a small number of targets to reduce the variability from state to state that seems to be in place today. So I wasn't necessarily suggesting that the ONC regulate or...I was suggesting that the ONC convene.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Thanks Eric for that clarification; appreciate it.

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

And then another comment made last time, too; I wanted to restate here that which even though it was not my comment, but I strongly agreed with it which is that also applies for other methods of public health reporting.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Any other thoughts on this slide on immunizations? If not, let's go on to the next one. Next is receipt of lab results. There is a question that was posed through the comments here about whether we should be moving on to some of the updated standards since a number of them are being updated now or hold for the next advisory on the current set of standards. I think this goes to at least some extent to some of our discussions on maturity; are there any thoughts about any of the revisions to these standards and whether...how quickly the advisory should move forward with revisions to the standards?

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

Excuse me; Rim, apologizing. Earlier we had a...on our last call we had recognized that there was a category of emerging standards or emerging work that we recommend that the ONC point to, observe and perhaps help shepherd, and I would think this falls in that category.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Thanks Eric.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

This is Janet; I'd agree with that.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Any other thoughts on lab results? If not, let's go ahead and move on.

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

So this is Eric; I'm a little confused on the grouping of lab orders and directory of services. This seemed like very different objectives and functions within the overall architecture. And these comments seem like they are largely geared towards lab results; does anybody else share that confusion? Are these indeed both lumped together into a single topic?

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

So Eric, this is Rim; yes, I share your confusion. Brett, can you clarify here? Just to make sure, so these actually were put together in the previous Standards Advisory and part of the comments lumped these two together as well?

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Umm, so these were actually I believe in the ISA these are listed separately but we pulled them together because many of the comments were the same; I'll double check on that now. In general it was hard sometimes to pull out comments that were for orders, directory of services and receipt of lab results because often groups lumped those together.

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

All right, I'm kind of mystified by the cate...these being brought together as well then because the...you know, lab results and orders are certainly part of a coherent workflow, from placing an order to acting on it and filling it and then receiving a result back. But the directory of services to me is a very different component within an architecture that typically would either be a directory of organizations or people and honestly it seems to be broken down between those for identifying say Direct recipients versus service endpoints for web services like the exchange uses.

And if that is indeed...if this is indeed all the comments we received, I think there's actually some additional areas to at least monitor if not be involved with; one is that last year the IHE created a standard called healthcare provider directories, which is a...I say created, it was done with the community including ONC, the exchange, health workgroups, the international community geared towards providing a web services based directory for doctors, hospitals and relationships between those organizations and providers, not just physicians. And also there is an existing international standard created by the IETF for a RESTful interface for a directory.

And then finally, I've heard that the Argonaut Project, of which I'm a part of now, was originally going to tackle provider directories this...over the next, you know, series of sprints. And as of last week, it turns out that's actually...looks like that's not one of the priorities and so we may have a gap here and that seems like many organizations are seeking a RESTful interface, you know, a simpler, non-web services based approach to directories and yet no one, to my knowledge, is actively working on those at this point.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

So Eric, this is Janet; I believe at least looking at the S&I Framework page that they have always grouped together LOI and eDoCs and that's why we're getting that being reflected here, in both the public comments and the question that the ONC posed originally. Whether that's the right way to do it or not I don't know, but that's probably why they're together.

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

Thank you then. I think my recommendation would be to break these apart.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Either that or, you know Eric, I share your thoughts about what the directory of services is likely referring to and it's possible that at least in the S&I Framework work, they were referring to something other than what it brings to your and my mind.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Well this is Kim and I don't know if I'm correct, but we did talk about this on the Standards Committee and we had Clem on there at the time who, you know, knows more than all of us about the lab stuff and how he described it and I could relate it in terms, like in the...world you have the compendia's which have all the medications in them that...

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

Right.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

...be a service is a compendia of lab services and lab orders that is more general than like a specific proprietary lab service so that you could connect through that compendia of lab services to make it more interoperable. Now I just looked back at our recommendations and we didn't feel like it was ready to be implemented at this time because there were some things that still needed to be done, but that's how I understand that directory of service for the laboratory.

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

Okay, so really this is reflecting not really so much a directory at all as a vocabulary of that which can be ordered.

**Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health**

Correct...this is Anne; it's a compendium of the lab ordering catalog basically where the...but it has other information like where that test is done and the methodology.

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

Okay. Oh, very good.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Well thanks for that clarification. I think Kim you said that the discussion was is that the directory of services standard wasn't ready yet to be released so it may be something to cite as an emerging standard?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

That's...and I, you know, I sent those to Brett right after our call on Thursday, I don't know if those came out. I copied the pharmacy stuff that we had talked about and then the last stuff; so maybe Brett you could pull those out and send them out to the group so they could see those.

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

I think they went out; those were the recommendations from the Content Standards Workgroup, is that correct?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yes, yes. Okay.

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Yes, I sent those out on...the group should have gotten them on Saturday.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay...

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Yes and I did get them, so, I do know...

**Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

We can resend them if needed.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Well given this clearer understanding, are there any other comments here? If not, let's go on to the next slide then. Next topic was patient education materials; there weren't any comments here. Are there any thoughts or comments from the folks on the phone? We talked some about Infobutton last time.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Does anybody know how this works, I mean, I hear things out in the field about patient education materials and if a provider wants to add their own materials into their system, it may not count...it may count against them with their Meaningful Use measure numbers. And they can only use like the defined ones that that EHR vendor has provided in their library; do we...does anybody have any knowledge around that or could shed some light and would this standard allow if an institution wants to add in some of their own educational materials if this would uphold that?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

So this is Janet; I can answer that. The Infobutton standard in particular is used for context aware searching of patient education materials, so it's actually just kind of like a search engine type thing where you can have a...it uses sort of query string parameters in a certain way to retrieve educational materials that are specific to a particular problem, med or allergy. So if you see like Medline Plus, for example, uses Infobutton.

If the organization is able to write something that confirms to the Infobutton standard, then that would be one way that they could do it. The certified EHRs as of the 2014, I don't know, whatever the Stage 2 criteria were, already had to support Infobutton. But that's separate from the ability to actually prescribe or otherwise direct educational materials to patients or teach them things. And an organization can use whatever content they want to for that as long as they're providing it in the system in such a way that the system can recognize it, basically.

So the thing in the system that counts whether the patient or whether the provider met measure P219 is look...I think its 219, it's the education one, the system has to be able to recognize that educational materials were given. But, other than that, that's...there's nothing against using personal materials or giving them out in a way that's non-standard; again, just so long as the system can receive it or can understand it. So there are kind of two things here; there's the context aware that's needed for certification and then there's the actual giving of educational materials, and that's what's needed for eligibility for Meaningful Use or for meeting Meaningful Use.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Thanks.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Are there any other...are there any comments on this topic? All right, thank you; let's move on to the next. Patient consent and this is primarily a question, are there best available standards for the purpose of patient consent or patient preferences?

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

So this is Eric; we're actually, for the e-Health Exchange, is using consent fairly regularly. One of our two or one of our main participants is the Social Security Administration, which is not a HIPAA covered entity and they require consents or really authorization for all transactions. And they're using essentially an IHE profile called BPPC and also another profile called XUA that stands for Basic Patient Privacy Consents and Cross-Enterprise User Assertion or Authorization and my recommendation would be, and it seems to be consistent with public comments as well, too, to recognize that as best available standards, and those are actually true standards.

And then I think there's a gap in that there is...those are rather blunt, as one of the commenters publicly stated and essentially they're saying either you're in or out in terms of you acknowledge this policy or not. And policy in this case is entire document. I think there's a need for computable consent and I've actually with my Texas hat on, written a specification that profiles an OASIS standard called XACML or "zacml" which is a rules based approach and several...quite a few of the public comments even mention that. The challenge though is XACML is not an implementable specification as is in that the vocabulary for those rules and the target for the expressions and the vocabulary for that which is being acted on is not defined.

And so my recommendation would be that we recognize IHE BPPC and XUA today. And recommend that the ONC at a national level convene work towards computable consent, potentially based on the XACML standard.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Yeah, this is Janet; I think the largest problem here is, as you pointed out, there's not a standardized vocabulary or roles or purposes or anything like that and that's a huge deficit putting a standard on right now won't solve, and maybe that's kind of what the first comment is talking about as well. That question needs to be answered at a national level before standards can support it.

**LeRoy E. Jones, MS – Chief Executive Officer – GSI Health**

This is Lee Jones; is that really the bar though? I mean, it seems like, I mean I know for projects I'm involved in we use XACML and is it still better to just have people doing that even if it's with local vocabulary agreements if you will versus, you know, national standards because it's sort of a step in the right direction, if that's where we really think we want to go ultimately.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

I mean I think that makes sense, I guess I'm just wondering about for the purposes that this Standards Advisory might be used, ONC said as much that we could use it as a, you know, people could use and adopt these standards and make them required for certain purposes. And I wouldn't want to over-represent what the standard will do without that sort of agreement on vocabulary that you're talking about.

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

I agree with both Lee and Janet, perhaps a revised recommendation from our group could be that the ONC recognize those three standards already mentioned, XUA, BPPC and XACML and that they also recommend a convening of a group to specify, as a next step, a vocabulary for the use of XACML.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

So Eric, I'm kind of thinking about the maturity framework that we...that often comes up at these discussions and in this case we have perhaps a relatively mature standard without implementation guidance and that may be a different way of thinking about maturity here, rather than a...

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

Right.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

...specific standard, a mature standard without implementation guidance.

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

Exactly and how I think about this Rim is that we have a national gap and a national opportunity to remediate that gap, specifically around computable consents.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Yup, I think that makes some sense.

**Calvin Beebe – Technical Specialist – Mayo Clinic**

This is Calvin; a question I have is does this get wrapped up in the multiple state rules issue that we have with consent?

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

I've actually thought about...this is Eric; thought about that quite a bit and HITSP also did some work on this near its last days about that exact topic. And we identified and published a draft white paper in HITSP addressing essentially everything that we thought a patient potentially would want to express in terms of preferences, of which consent is just one of them.

And one of the benefits of a XACML-based approach, or any kind of a, you know somewhat rules based approach is that it at least allows those variations in law to perhaps be identified in a computable manner, as opposed to right now requiring point-to-point legal agreements to reconcile this. So to answer your question, I view this as being potentially a way to take a stab at computing those rules. For example, one area of large variations from state-to-state, as you're probably aware is on youth and reproductive health. And what this could do is perhaps give us a chance to create a list of the various rules related to reproductive health in minors and consent, especially for release of information. So at least the state-to-state variations could be processed programmatically rather than requiring human intervention. Does that make sense, Calvin?

**Calvin Beebe – Technical Specialist – Mayo Clinic**

Well, it may be what's...I think this comes back to the question of, if there's not a significant implementation out there, there's a lot of learning that hasn't taken place yet with vocabulary here.

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

Yup, I agree. And there are some implementations of XACML, but, they're largely unique. I think New York has deployed XACML, Texas has specified XACML, but not fully gone live with it. I think epSOS and some European deployments exist; so certainly we're low on the learning curve, I agree.

**Calvin Beebe – Technical Specialist – Mayo Clinic**

Right.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Thank you, good discussion. Any other thoughts on this topic? It sounds like we've got a recommendation there that we can move forward with. Let's move on to the next slide then please. Next topic is quality reporting in an aggregate. There weren't very many comments here; are there any comments of the task force?

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

So, this is Eric again. I just want to pause in case I just wanted to chime in, too. One issue I'm seeing right now in a live project I'm involved with here in Texas is that long-term care has their own reporting requirements and minimal data set, the MDS. And those were developed apparently somewhat independently of the rest of the industry. And so one thing I would want to suggest we do is we try to ensure that the quality reporting metrics are as much as possible similar to the metrics used for other national priority use cases so that we can leverage the overlap.

In long-term care support use case, there's actually, for example, at least one vendor now coming to market with a product that will take and turn the...all the reporting data into a clinical data repository and into a C30 or a CDA document, but it's been, I guess, challenging to do that. And so I think it would be good if we actually reconciled those efforts to try to make sure reporting data and clinical data can be brought together and used for cross-purposes as much as possible rather than being independently developed.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Any other thoughts? Thanks, Eric.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

This is Kim, I may get the name wrong, but John Derr led an effort with, Anne, maybe you can help me out if you remember the long-term care initiative and I thought they did try to reconcile some of those things, or...

**Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health**

Kim that was my understanding as well...this is Anne. I'm madly looking through for John's slides.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yeah, maybe we can look those up and send them out to the group as a reference. But I know John Derr has worked on that and Eric, I'm pretty familiar with the MDS because in my previous life I consulted

with a SNF unit and had to meet those requirements and they are fairly different than like a clinical quality measure type of initiative.

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

Right.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

But I believe there have been efforts to try to reconcile that as much as possible and there were actually, like the data elements needed for the long-term care was significantly larger than what you needed for maybe a quality measure. But...

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

Right and the big gap I'm aware of is that the MDS for long-term care, I believe does not include problems or medications, one of those two I believe is absent, which they have the information, they're just not part of the standard being exchanged which represents a potential lost opportunity for us to, when that same data is repurposed for a care summary doc based on CDA.

So, if it's possible, I think my recommendation would be to...for the ONC to try to explicitly convene work related to ongoing reconciliation of these standards. An example, make sure that any MDS required for long-term care also includes valuable data they also probably already have at their disposal such as problems and medications that right now are not part of MDS and similarly for other segments of the healthcare space.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Thanks Eric. Any other thoughts? Okay, let's move on to the next slide then. This is patient level quality reporting and there wasn't much in the way of public comments here. Are there any comments from the task force?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

I'm actually kind of surprised that nobody objected to R2. I'm for it, so I think that's fine but that was the comments in other places.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

It was in other places and I noted that as well. It may be worth noting here that there may be some utility in making sure that we either move forward with R2 or do not move forward with R2 across the board rather than, you know, providing variability depending upon the topic of the standard. Would that be your recommendation?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Yeah, that would...

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

...curiosity. Any other thoughts on this measure...on this standard? Okay, if not, let's move on to the next, to segmentation for sensitive information. So I know that there has been some interest in DS4P and that's called out in the comments here and I do know that there is some motion moving forward to that standard. I don't know for sure exactly how far into that...how far...how much progress has been made in the pilots. Are there any other...are there...I'll just pause there, are there comments about how to approach this?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

This is Janet; I know from our perspective we've been extremely concerned about DS4P because it's a standard that hasn't yet figured out the implications, clinical and otherwise, of what it's trying to do. And it's something that I think that it would be really unfortunate if it got put into a Standards Advisory without those questions being answered.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

I have to say...this is Rim; I have to say that I share your concerns about that. Do you have a thought about how we might resolve that? You know, Eric has had a couple of suggestions during our meeting this time and last time about ONC convening stakeholder groups; is there a need here too for ONC to convene a group not to think about the standard, but to think about the workflow or other clinical implications of implementing this?

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

That might make sense. I think what's happened in the past is sometimes some stakeholders get overrepresented and others get underrepresented if you think about, like if you look at the initial DS4P Initiative. So making sure that there are clinical representation as a part of that group I think is going to be something really important. But yeah, it almost flows into the consent question as well.

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

Exactly, in fact one of the pilots I think uses various forms of consent such as BPPC and XACML. One of the recommendations made was to focus just on a subset and there were quite a few comments...other comments about behavioral health. One question that I think is lingering in the industry is what's the game plan as far as 42 CFR Part 2 information. I've heard that it was unintended...and unintentional barrier to exchange that the original regulations were not intended to require point-to-point authorization for the purposes of blocking exchange, but they would actually predate health information exchange in many cases.

So my recommendation on this in particular is to see if the ONC can coordinate with other federal agencies that are involved, such as SAMHSA, on sensitive information exchange to see if we can clarify what is and what is not allowable and what is not intended as far as behavioral health and other sensitive types of information exchange. So if we can get a clear definition, because right now the current regulations largely have the...especially 42 CFR Part 2, have the intent of making it very onerous and difficult to exchange behavioral health information. And I don't know if that was the intent or not, but that's the, I think, at least my opinion of the outcome and result of the current regulations.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Thanks Eric. I do know...I think that's a good suggestion. I know that SAMHSA has been having some educational sessions and I've attended one or two of them. Mostly they've been about educating clinicians or other stakeholders in...to the requirements of Part 2. I haven't gotten any feeling from those meetings that SAMHSA believes that there are unintended consequences outside of a misunderstanding of what the regulations actually require or any intent to revise them, but perhaps others know better than I.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

I know that certainly even in talking to people, I've heard just crazy interpretations of this kind of thing including having to get consent in order to e-Prescribe because it's sending, you know, mental health related information to an outside entity. And I guess that doesn't help, but I think that this...there are very few people out there who actually are getting it exactly right and it may be possible that that's not possible in the world that we're in right now.

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

My final suggestion on this topic is that, I also have concerns about DS4P in general, but the IHE Technical Committee that I'm a part of actually reviewed this in some detail and accepted a subset of that into a new standard. And so one of my recommendations would be that the subset accepted for US realm implementation under IHE, ITI on the Technical Framework Volume 4, National Extensions, be pointed to as a best available standard.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Eric is that just marking at the document level, the metadata there or...

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

It's marking at the document level and includes, among other things, the obligations. So if, for example, if it's for substance abuse treatment, the markup would include that this is for substance abuse treatment for alcoholism, which is actually what the regulations currently require. And then you could have an obligation that's also associated with that list of the attributes. The second attribute is an obligation such as this cannot be re-shared or something similar.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Okay.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Thank you, Eric. Any other thoughts on this topic? Great, let's go on to the next then. The next topic is summary of care record. We had already talked a little bit before at today's meeting and at past meetings about the benefits of our R1.1 versus R2; are there any other thoughts on this topic?

**Calvin Beebe – Technical Specialist – Mayo Clinic**

This is Calvin; the only comment I'll make is there is a 2.1 Consolidated CDA guide that's just finishing a consensus process at HL7, which I think will become available for publication in two or three weeks. It tries to undo the backwards compatibility issues or some elements of the backwards compatibility issues

that existed between 1.1 and 2.0 that required two documents to have to be proposed to be sent. I believe the idea, the way it works is that it...a receiver of a 2.1 who's running a 1.1 based application could still minimally process correctly as opposed to not process a 2.0 document. This was an effort at the standards group to deal with this; I don't know if that's of merit to mention as a consideration or if it just is just something to note to the group.

**Janet Campbell – Vice President of Patient Engagement – EPIC Systems**

Seems like it's worth mentioning; I know the backwards compatibility has been the biggest issue I've seen with this and I really would not like to have to support multiple versions of a document if we don't have to.

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

Well Calvin, this is Eric; thanks for making that comment, I was going to say almost exactly the same thing. But I second your thoughts and I do think it's worth mentioning because content is, from my vantage point, one of our biggest challenges at a national interoperability level right now and whatever we can do to ease the burden and maintain compatibility is just going to help everybody. So, I would strongly advocate that the ONC look at 2.1 as an emerging standard.

**Calvin Beebe – Technical Specialist – Mayo Clinic**

Right.

**Christopher J. Hills – DoD/VA Interagency Program Office**

This is Chris Hills with the IPO and for what it's worth, I agree with everything that was said as well.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

All right, thank you. Any other thoughts? If not, let's move on to the next one; I think this is our last topic for today, syndromic surveillance. Are there comments here?

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

I'm just looking through the public comments. So I am...I've been involved with a couple of syndromic surveillance deployments before, including for some other states and what I'm struck with is that there's actually no true standard. There largely are pseudo-standards in use today for that, largely promulgated by the CDC and the challenge with that, from my vantage point is that it hasn't gone through the full standards process, but it still has a lot of the effect of a standard.

And so I would suggest that, if others agree, that this actually become a true standard and that ONC put some effort into making it such. I think over time this is actually going to become one of the most useful uses of health information exchanges and it would be a shame to not be able to leverage that because we have many different variations of public health data reporting.

The other challenge I would like to see the ONC convene a group to address is the fact in many cases the initial diagnosis upon admission to an ED is not codified or certainly has not been codified historically until somewhat later in the workflow, or the chief complaint is not codified or initial diagnosis is not codified in many cases and that limits the ability for us to get syndromic surveillance information in a

timely manner. And so I think that's a gap that we should also ask the ONC to work with industry and others to remediate.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Good comments; thanks Eric. Any other thoughts? Well if not, I believe that brings us to the end of our slides today, the end of the comments that were on our agenda to consider today. Are there any other final comments on Section II before we move on?

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

I guess I have one final comment on syndromic surveillance. There actually are some standards in existence right now that can be used, but they're imperfect. One is HL7 251 and another is the IHE has created a standard called document submission and administrative distribution are the eHealth Exchange specifications that leverage some lower level IHE profiles and those can be useful for this type of a purpose as well as for other purposes as well, too. So, there are some things we can build on.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Right. Thanks, Eric. Anything else? Well if not, then I think that we're ready for public comment; we can open the lines for public comment and see if there's anything submitted through chat.

**Public Comment**

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

Caitlin or Lonnie, can you please open the lines?

**Caitlin Chastain – Virtual Meetings Specialist – Altarum Institute**

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

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

Do we have any public comments submitted through chat?

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

We do, but I think it will be easier to distribute to the workgroup via e-mail. David Tao left a comment that I'll share with the group, it's just a little bit detailed to share verbally. And it looks like we have no public comment.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

All right, so our next meeting I believe is scheduled for Thursday of this week, is that correct?

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

Yes.

**Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges**

And for Thursday's meeting we'll be looking at comments for Section III and Section IV, if we can get into that as well. Is there anything else to come before the task group before we adjourn today? If not, then thank you very much for attending and your good comments and discussions today and we'll all see you again next Thursday. Thank you very much.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Thank you, Rim.

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

Thanks everyone; talk to you on Thursday.

**Public Comment Received During the Meeting**

1. David Tao (ICSA Labs): eDOS is not a directory of providers, but a directory of orderable tests. From S&I description: "The Version 2.5.1 Implementation Guide: Laboratory Test Compendium Framework, Release 2, DSTU R1.1, is a master file framework Implementation Guide (IG) for the electronic delivery of a laboratory's Directory of Service (eDOS) to all providers that order lab work including EHRs, HLIS, and others. This provides the mechanisms to provide initial Directory of Services and periodic updates leveraging the HL7 standard and electronic transmissions. This provides the Orderable Tests for a laboratory, the components, specimen information and description of what is provided including information needed from the patient that has an impact on the results of the test .."
2. David Minch: Dave Minch; HSBA; Lab & Directory of Services - is this actually referring to CSD (care service discovery)?