



HIT Standards Committee Implementation Workgroup Final Transcript August 11, 2014

Presentation

Operator

All lines are now bridged.

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

Thank you. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Implementation Workgroup. This will be 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. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'm here.

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

Hi Cris. Liz Johnson?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Here.

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

Hi Liz. Anne Castro? David Kates?

David Kates – Senior Vice President Clinical Strategy – NaviNet

Here.

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

Hi David. Gary Wietecha? John Travis?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Here.

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

Hi John. John Derr?

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi John. Joe Heyman? Kenneth Tarkoff? Kevin Brady?

Kevin Brady, MS – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Kevin. Michael Lincoln? Nancy Orvis?

Michael J. Lincoln, MD, FACMI – Director General Standards – Veterans Health Administration
Here, Mike is here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thank you. Sudha Puvvadi? Tim Morris? Udayan Mandavia?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare, Inc.
Yes, here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hello and Wes Rishel?

Wes Rishel – Independent Consultant
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi Wes and with that I'll turn it back to you Liz and Cris.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, well, I think that you and Cris had a great discussion with several presenters last time to really sort of look at the primarily vendor experience with the C-CDA but I think in doing that probably there was some understanding of what the end-user was experiencing as well. So, today Cris and I want to go through sort of the summary of those experiences and then talk about potential recommendations and those would go forward to the Standards Committee.

And I think that Michelle and Cris, and I are looking at asking the Standards Committee to do a much deeper dive on this, because I think we've discovered that there are some real issues, but I think, you know, getting through sort of the summary of what was heard and ensuring that it reflects what you heard and then adding potentially to that with our own experiences from a provider, you know, either physician or other hospital sort of experiences would be helpful. So, I think that's where we want to go today. Cris, do you want to comment?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Just briefly, I think what we heard in our last meeting was a lot of detailed information about the C-CDA that's going to require some real expertise to untangle. So, as we did some planning for this call this group is really the one that's called upon to identify issues and call for action that's our current charge and as our new charge as a new Workgroup evolves it's in the same direction.

So, as we walk through today we may not be the group to resolve the technical semantic, vocabulary and other issues associated with C-CDA but it's our role to call to action so that it can get resolved and we may have some discussion as we go through the day about which other Committees and Workgroups of the Standards Committee we might want to pair with in order make progress on this issue.

So, I think our conversation today, Liz, improve on this as appropriate, but I think what we're trying to do today is to understand the issue sufficiently that we can frame it, that we can understand, you know, what actions need to be taken and then decide what venue and with what other collaborators do we want to resolve this issue. Does that sound accurate to you, Liz?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

It does indeed. Any questions from the Workgroup? Great, why don't we move on then and Michelle, do we have any folks...Michelle is playing multiple roles, as if she had time, but she's been our leader from a coordination perspective both for the Standards Committee and for this Workgroup as well as done a lot of what we would have the staff members, so Michelle is it...do we have Scott or anyone else, or is it us today?

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

It's just me from ONC today.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Wes Rishel – Independent Consultant

Question?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes?

Wes Rishel – Independent Consultant

Elizabeth this is Wes and I'm sorry to say I missed the last call and I have been listening to the notes but I'm not complete yet.

To what extent were these reports hypothetical in the sense of I look at the standard and I see these problems and to what extent were they serious, were they experienced-based, we tried to implement and found these problems?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Cris?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Wes, I would say that it was probably 80% experience-based and 20% theoretical. I think when we talked about potential solutions in the very first meeting, we had one set up meeting where an ONC expert framed the issue, that was a pretty deeply technical and some of the solutions and alternatives described were not field tested necessarily, but potential solutions and I guess you could call it theoretical.

I would say of the six presenters that we had the vast majority of the discussion was here are ways where we are having trouble today getting C-CDA content consumable by receiving parties.

Wes Rishel – Independent Consultant

And that was the meeting that was just about a month ago is that right?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

The first meeting, the first briefing was about a month ago, the expert's panel was about 2 weeks ago.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

It looks like there is more than I thought, okay, thanks.

David Kates – Senior Vice President Clinical Strategy – NaviNet

And, I thought, Cris...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'd also say there were folks here who were representing, you know, there are some vendor names next to people's titles.

Wes Rishel – Independent Consultant

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But they really were talking about the challenges that their customers face.

Wes Rishel – Independent Consultant

No, I understand that distinction I'm just...when I started looking at the materials I didn't appreciate the full content of what had been said so I'm glad to get updated. Thank you.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah and Cris, this is Dave Kates.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hey, Dave.

David Kates – Senior Vice President Clinical Strategy – NaviNet

I would concur with what you said, I mean, I think it was 80/20 experience-based from a couple of different perspectives, one from EMR vendors and sort of what they experienced in exchanging C-CDAs, also secondary uses of C-CDA like Micky Tripathi and the Mass eHealth Initiative and their ability to mine the data and such. But, just adding color to your comment I think it was very much practical experience-based not just academic, intellectual, here's what could break in the context of the standards as they exist.

Wes Rishel – Independent Consultant

Okay, thank you.

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

Hi, Cris and Liz, this is Micky Tripathi, I just wanted to let you know I'm on.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hey, Micky.

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

Hi.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Oh, great, hi, Micky, it's nice to have you on.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Glad you could make it today.

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

Great, thanks, I'm going to have to...I apologize I'm going to have to drop off just before 1:00 but happy to join.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, before you sign off Micky do you agree with what we were talking about in terms of testimony presented in the last meeting? I mean, you're sort of boots on the ground here.

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

Yes, yes I do.

Wes Rishel – Independent Consultant

So, just to help me reorient, most of the experience we had was based on the C32 right but what I'm understanding these meetings are about is the C-CDA which was a set of changes made in response to issues with the C32 and I'm just trying to determine that the experience described was based on the C-CDA which would have meant relatively recent implementations...

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

Yes.

Wes Rishel – Independent Consultant

As opposed to the older experience which I think is perhaps not as well understood as it should...

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

Yes.

Wes Rishel – Independent Consultant

But at least among this committee.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah that was a...this is Dave again, that was specifically noted and while you're right there are fewer C-CDAs and less experience on it that was the specific topic of discussion.

Wes Rishel – Independent Consultant

Okay, thanks.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Liz, I think we've tee'd this up about as well as we can.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I think you're right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Maybe we want to walk through the agenda.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I think you're right, let's keep going. So, we're going to...

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

Liz, this is Michelle, I'm sorry, you're just a little hard to hear if you're on a speaker and you can switch to a non-speaker line that would be great.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, is this any better?

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

Much better, thank you.

Joe Heyman, MD – Whittier IPA

Excuse me, this is Joe Heyman, I just have been having some computer problems so I just heard Wes at the very last part say something, Wes, was he talking about the eHealth Initiative Group?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, Joe.

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

No.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

He was asking whether or not the experiences that were discussed at the last meeting were related to C32 or C-CDA.

Joe Heyman, MD – Whittier IPA

Oh, okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay? So, I think today we're going to go through a summary of the user experiences and look at some recommendations and certainly take public comment. Do you want to go to the next slide?

I'll remind you the charge and then Cris I'm going to ask you to go through the summary because I was not at the last meeting either.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sure.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

As we all remember we were really looking at where there any usability challenges with C-CDA version 1.1 for specification as well as the implementation guidance and if there were if those challenges were hindering interoperability what did we believe that the ONC could most effectively do to address those issues including future versions of certification program. So, that's what we were charged to do. Next slide, please. Keep going, please, and the next slide. And Cris you can take it from here.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sure, so you see listed the folks who presented and its wide range of representation from a number of different venues. A number of these folks were involved in some of the C32 to C-CDA evolution and had real practical experience. So, if we can go to the first slide, please.

And these are presented not by a presenter but by general topic. So, you know, the kind of challenges that we're seeing was the wide implementation variation, the target that was set in our first conversation when we received expert summary from ONC was a target to make 95% of C-CDA material consumable by a receiving institution and the challenge was not around transport, it's not around consumption of the C-CDA itself it's around the actual computability and usability of the data that's included in it.

The overall view-point was around the existing standard and implementation guide allowed too much variability in some cases optionality, in some cases different kinds of variety and how something can be expressed and so on.

So, a third issue was really the question around, you know, is too much information shared. There is a lot of need around pertinent clinical summary. I know that it's the case, you know, just speaking as a sample set of one at Mayo we struggle sometimes with really voluminous documents. In some sense they can be very, very helpful, in other instances, you know, not so much.

I've talked with vendors who, you know, have convened groups of CMIOs for example who are, you know, really frustrated that their clinicians receive these large documents and they simply don't have time to do the work to do the manual extraction and use of data.

So, you know, it probably starts from a point of goodwill and good intent to be inclusive with the information shared but on a practical basis those of us on the provider's side really do struggle with the consumability of these big documents.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Cris can we...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I just wondered Joe are you looking at C-CDAs and are you using them in your practice?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You beat me to the punch, that's the perfect question.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Joe are you on mute?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, we'll invoke the Heyman rule later and ping him again in a second.

Joe Heyman, MD – Whittier IPA

Hello?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hey.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

There he is.

Joe Heyman, MD – Whittier IPA

Hello?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Hi, Joe.

Joe Heyman, MD – Whittier IPA

This is Joe am I now off mute?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You are off mute.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

You're off.

Joe Heyman, MD – Whittier IPA

What was the second part of your question, Liz?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I was just asking if you are using...as you receive C-CDAs from hospitals where you practice are you using that data? How are you using it? How is it being consumed in your practice?

Joe Heyman, MD – Whittier IPA

Well, I retired from my practice in March and we were not using C-CDAs although I could produce one and import one.

And now I'm working on a health information exchange and we are extracting HL7 rather than C-CDAs for most things. We will be extracting C-CDAs from a SAF situation but I guess what I would say is there is such variation.

We produce a C-CDA for our HIE for patients to look at which I think right now has very little positive information for them and I've seen C-CDAs that have the reason for a visit and what the plan was and I've seen C-CDAs that have absolutely nothing in them. So, I think there is a real problem with C-CDAs.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, the other thing that came up with our patients, and so Micky I would also ask you the same thing, is many of the C-CDAs are in clinical language that patients don't understand, certainly a clinician could understand it, but they're not patient friendly. Is that a unique finding or a universal finding?

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

Well, this is Micky, I can...from my perspective I would think that that's probably pretty universal because the C-CDAs are being generated...I mean, unless it's a C-CDA that is being generated specifically for patient consumption and has some type of, you know, sort of processes behind it to try to change some of the, you know, terminology it's going to be in whatever is being reported for clinicians.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Wes Rishel – Independent Consultant

This is Wes I'd just say that's the overt purpose of most CDA derived documents at least if not all is clinician to clinician transfer of information.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I think that's true Wes, but I think that it's also being used as the basis for providers of patients and...

Wes Rishel – Independent Consultant

I agree, Blue Button, for example would be one way that could happen and that I think represents an issue that would need to be addressed at the level of creating a new document specification as opposed to calling what's happening now wrong because it doesn't meet an added on specification. I mean, I agree that the problem happens I just think that as we triage issues it will fall into a separate category.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And I'm fine with that but I'm thinking...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Go ahead, Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, this is Cris; I guess we should perhaps parking lot this issue and come back to it. I would offer an opinion which is we have a really pressing industry challenge right now in the consumability of C-CDAs and if...it feels as though, and I'd love to get feedback from others, but it feels to me as though that issue needs to be solved with a high level of urgency and it's not clear exactly how we're going to get there and how fast we're going to get there.

The amount of frustration that I have heard via, you know, our various vendors who are engaged in this space and from our clinicians is, you know, we're putting too much of a workload burden on clinicians or their support staff to deal with the non-consumability of C-CDAs.

An awful lot of fantastic work was done to get from C32 to C-CDA and it was built on very practical experience by a lot of people on this call. So, you know, if they want to speak up please do so, but, you know, I think that we may want to separate the patient issue from the provider issue because the provider...not that the patient issue isn't also, you know, vitally important, but I think if we try to kill two birds with one stone or if we try to take on both of these issues in the same bucket I'm afraid that we may not get to a good conclusion.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right and...

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah and Cris...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Go ahead, Dave.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Real quick, it's Dave, so I totally agree, I mean, I think the two uses cases not related to the patient DVT requirements or VDT or what it is, view, download, transmit that we're hearing most from our members, from our customers that their trying to solve a C-CDA is one to automatically populate patient clinical data like problem list, medication lists, prior lab results things like that without the need to go and interpret human readable style sheet displays of the data that's presented in the C-CDA.

And second is the types of analytics to be able to go and see, you know, quality measures and things like Micky spoke to in the Mass eHealth Collaborative use cases. So, to those ends that's what we're focused on in trying to get some more consistency beyond what we're seeing out in the market.

Joe Heyman, MD – Whittier IPA

Yeah, this is...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Hey, David, can I ask you one quick question?

David Kates – Senior Vice President Clinical Strategy – NaviNet

Sure.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

When you say automatically populate patient clinical data into...I'm presuming either into the HIE that then can be translated into their EMR, does that...so it becomes a non-touch sort of happening, I put the information out there it populates my EMR in my practice and I'm able to use the data?

David Kates – Senior Vice President Clinical Strategy – NaviNet

Partly, so, you know, you're a specialist that is taking a patient from a PCP you want to see what medication they're on and it could be mediated by an HIE, but there are also other use cases like, you know, in population health types of examples where you refer a patient to a care manager and the care manager wants to have that information readily available within their workflow application separate from the EMR.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Got it.

Joe Heyman, MD – Whittier IPA

And this is Joe, can you hear me?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

Joe Heyman, MD – Whittier IPA

I just wanted to mention one other thing which of course would actually make the problem we're trying to deal with worse, which is the lack of history that appears in a C-CDA, past history, surgical history that kind of stuff. So, there is that problem that sort of conflicts with the problem of trying to constrain them.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right, so, Joe that's probably a good segue for us to continue to move forward on this discussion if we've closed the issue around patient versus provider, but we'll get to a couple of really pertinent examples around that, how do you create a sufficiently thorough view of the patient but in a way that the data is not overwhelming and is usable.

Again, I'd say a sample set of one, we received patients at Mayo Clinic who have a very specific problem to be addressed but we also have a fair number of medical oddity type cases where, you know, seeing a thorough, broad, deep record is useful and, you know, how do you hit both of those instances is it going to be a challenge?

I'm wondering, I feel like, unless anyone wants to have sort of a last word on patient versus clinician issues I'd like to keep walking through the rest of these slides.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Sounds good.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, again, the issue here, this third bullet point around summary documents being at this point vendor discretion with a general view of current implementations typically have too much information one need is around pertinent data and the second one is what do we do around these 17 required data elements and one of the biggest issues was no instruction for when an element is not present. And a good example here is around NullFlavor fields being available, but does the implementation guide and available examples give consistent and tight enough guidance about what to do in those instances?

Could we go to the next slide, please? So, a second general category was that the certification process itself focused on the creation in and the transport side but not the intake. A lot of discussion around testing required around vocabulary the three main vocabularies are listed here.

The variation in how medication intolerances and allergies, related to either environmental or substance are handled.

A third issue around data versioning within the C-CDA so that where there is the problem of data correction in the case of errors requires manual intervention and again this is an example that providers are facing now that a C-CDA can be received but where the data versioning is not consistent with the receiving EHR it throws an error, which is totally appropriate behavior, but when that happens how does a clinician handle those error cases some of which require, you know, interpretation and where there is interpretation there is the potential for error.

And then the last is that many C-CDAs have instances that have more specificity in the narrative section than the discrete data section.

So, again, speaking from a sample set of one I know that our clinicians highly value narrative as a way of understanding a case that is presented and they also want to have the ability to provide narrative when a case is returned to a referring physician or where there is transfer of care.

I know that there has been...I've received some great input from, you know, a well-known informatician, acting clinician, who said that they really like the summaries that they receive from us because of the narrative piece of it and, you know, we hear that often. I don't want to talk too much about Mayo, but it feels as though practical experience may be useful.

So, the issue is, you know, are we over constraining potentially the narrative section but not doing enough around the discrete data section where some of the problems exist?

Can we go to the next slide? I thought I'd walk through these slides and get to the challenges then people can speak to any of the challenges and then we would transition into solutions. So, if we could go to the next, sorry, one slide back, oh, I'm sorry there were only two that's right.

Actually, let's pause here on the challenges before we go to the summary of solutions. Does anyone want to comment on any of these challenges or are there others that were not either represented out of the testimony, or are there comments that people would add based on their own expertise that may have been missed in the testimony?

Joe Heyman, MD – Whittier IPA

This is Joe, can you hear me?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

Joe Heyman, MD – Whittier IPA

Okay, the *6 doesn't work very well. I just want to say, first of all I agree with you 100% about the narrative being very important that's what I was mentioning about the reason for the visit and what the plans were at the end.

The other thing I wanted to point out, which I don't think I've pointed out before, is you know, the problem list is something that was created for paper charts, it was a way to look at one piece of paper and see what all the patients problems were and I don't know why we're racking our brains on how to use a problem list for electronic medical records because I don't think you really need it for an electronic medical record most of the problems are on one side of the screen and on the other side of the screen is where you're entering notes.

But in any event, some of these problem lists get very, very long because people don't resolve the problems and then they become useless as well, but I just wanted to add that to the stuff that we're all talking about.

But, I agree with you 100% Cris that narrative part is very important and that the discrete data ought to be importable or at least you ought to be able to import the entire C-CDA just as a PDF but in some easy way, but it would be much better if you could just import the information I guess.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Cris, this is John Travis, I have two other thoughts, one and it probably fit with some of the vendor variability that was similar to your comments about allergies and I think you said medication reactions, but the expression of no known for the various clinical data types that the specialty or the ones that are subject to required vocabularies there is no real good guidance and it's as much a certification comment as it is an importive data comment.

There is no real good guidance on how to express no known or none available versus a null condition. So, that's been left to the imagination of the vendor seeking the certification, so that probably is an area that needs to be addressed.

And I think the other thing I heard in the testimony was both...especially, I think as the sending provider producing the transition of care summary we have a problem of over prescription about what has to be produced and seemed to have not taken into great account the discretion of the provider producing the thing to produce a useable summary.

So, you know, maybe from a use perspective we've gotten too into the weeds about requiring a set of content and, you know, setting perspectives of longitude or time about what needs to be on it versus the provider really determining what is usable and that maybe takes you into the workflow question of how do you expose all the stuff that's going to be on the summary to make it a manageable process for the provider to exercise that discretion. But that's something I think we were hearing that in turn helps contribute to the usability of what is received.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, John, this is Liz, let me ask you a question, when...I think I understand your comment, I think the dilemma I see is, what we've been through so many times with the Implementation Group, of where you put in specificity and actually constrain the C-CDA so that for two reasons, one the vendor knows what to provide and the provider knows what's going to be available for them to use and as much as I like the narrative in terms of understandability and usability it does present problems in terms of being able to data source it for analytics, but on the other hand it might solve your problem or what you're saying was described.

So, if you'll just comment to can we give the flexibility that you're describing or anyone comment without creating kind of what's already been created which is almost too much variation.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, this is John again, it kind of fits into two categories and Liz you probably will empathize with what I'm about to say, the first category I'd say is discretion to clean up the crap, pardon my French, and that's just the transcription can clean that up.

Wes Rishel – Independent Consultant

I think that was an accident.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

But we've had a lot of issues especially with the problem list getting to really what are the conditions that represent the active problem list, because, you know, we have long-time EHR user clients that have used the problem list to document other things or they've documented things in narrative form and it goes towards what Joe said of, you know, it's not very cleaned up.

And I think the whole experience of Stage 2 this year for us with a lot of clients has been, do I have to include all of that stuff that, you know, if I come under audit someone sees that I reported out 10 rows of problem information and in my view that's the problem list and I've got 50 rows of data but the rest of it I don't think is terribly useful or it's redundant, or it's something else, am I going to get dinged for that and it's created an awful kind of trepidation of what to do about that stuff.

We've had clients ask us to do everything from sequestering the stuff that really shouldn't go out and be able to put it into another status or another bucket to people saying, help me translate narrative text into...for problem and do all that.

I think the second category is more what you'd be concerned with though, Liz, which is you can overdo the point and, you know, there needs to be some degree of automation that can support the provider to include things without them having to take so much time at it that it still assures completeness. So, there is definitely a balance in there.

Problems is fairly unique in that it it's been used that way I think some other things become easier like medications or immunizations where the active record once reconciled you include it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, yeah, no there is no question and Cris I have to tell you that when I read the notes and when I read the summary slides I thought that there are examples of using medication intolerances versus allergies, a whole different conversation unto itself. Whoever does this and gets the C-CDA to where it needs to be so it's more usable that's going to be a huge challenge.

But, I just, you know, to me as I listened and as I read I just got concerned about how do we find that balance and maybe it's not us that finds it, but as recipients of C-CDAs, and like John was eluding to and Joe was eluding to and you Cris, we're trying to make this data that helps us take better care of the patient and I don't know where the forgive me sweet spot is around this narrative versus null values, versus...and maybe the standards people can come up with it, but I think applying a standard to a practical world, and maybe that's one of our recommendations at some point, once the standard is devised can we develop some case studies to test it before it once again becomes thrust upon the world.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

You know, Liz...

Wes Rishel – Independent Consultant

Wes, here...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think that's a really good point. Wes you may want to add a comment, but actually I think this conversation might be framed well, I know I paused here for the challenges, but we may want to walk through the summary of solutions and recommendations and then open it up for broad conversation, but Wes did you want to comment?

Wes Rishel – Independent Consultant

Well, I just wanted to build on what Liz said in the following sense, I'm hearing two or three problem points here, one point is on the mechanical ability of the C-CDA specification to support unambiguous transport of structured data to the degree required by the Meaningful Use Stage 2 regulations that there are issues where because of vagueness in the standard the conformance can't be tested or because of budgetary limitations on conformance testing time they aren't being tested it leads to simple computer to computer misunderstandings.

The second broad set of complications relates to the usability of what is transferred and I'm going to say the difficulty of use rather than usability in the following sense, we talked about problem list which has always been a difficult issue to implement among the users of a single EMR much less across the EHR, much less across them.

We talk about volumes of required data or volumes of data that might be useful to feed an analytics operation that in some sense conflicts with the believed purpose, which is to convey from one clinician to another what's going on about this patient. The model there is conciseness and that model comes out of people's medical training.

And so, I think one way we may want to look at how to sort issues out among these two levels of problems is what would make, if anything, would make Meaningful Use Stage 2 fail using, pardon the expression the "F" word there and what would make it more or less useful as opposed to outright interoperability not happening. Thanks.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, I'd like to just walk through this summary of solutions and recommendation pages here I think that would help us move the conversation along. So, if we could advance to the next slide, one more, the solutions, thank you.

So, there are three general solutions here and then there are some recommendations. So, the first one of these, we're already talking about these so I thought it would make sense to walk through them. The first summary solution is, you know, needing more detailed and constrained specification including clinical use cases around common issues such as, and you see what they are, they were in the testimony and we've started to discuss them already, medications, problems, allergies, co-mingling of medication intolerances and allergies and then specific use cases as a way of thinking about how to make the documents more usable based on use, why are we moving this data and for what purpose.

The second general solution recommendation is to publish conformance tools so we can optimize and validate real world instances of C-CDAs, you know, I know that I'm lecturing the professors here, I'm amongst my betters so I say with humility, a lot of people here know that we're in early days and have participated in lots and lots, and lots of activities in the past where you don't necessarily get it right the first time out and the goal is to iterate rapidly in order to improve and I think there was a lot of discussion around how can we increase the rate of iteration so as to increase the rate of the improvement.

The third solution proposal is to evaluate the standard and implementation guidance in a way that separates clinically relevant narrative content from discrete information and we've already talked about providing opportunities for physician and patient discretion around, you know, what is in that narrative and how it is formed. I thought these three recommendations in general were well described by staff at ONC. If we could go to the final one around recommendations then I think we can just open it up for general conversation.

Three recommendations detailed and constrained specifications also including clinical use cases to address common issues so this opens up the possibility of C-CDAs that have flavors or purposes.

The second is around publishing conformance tools as just described and do we establish a site with public samples of these documents, sections and entries so that we move away from vendor specific to more broadly shared.

The third around the separation of clinically relevant narrative content from discrete information and the fourth is we proposed that we would charge another Workgroup of the Standards Committee with the membership that could review these challenges in more detail specifically around content standards or semantics standards that get into more detail and we may have the possibility here of working jointly with another Workgroup. I think there are a number of people on this Workgroup with specific detailed expertise and potentially on others so that we could drive this forward.

So, I think at this point we probably want to continue our general conversation both around the summary of solutions and recommendations as well as any other additional comments that people want to have about challenges. I think we're having a pretty effective and free-formed conversation anyway so let's just open it here.

Wes Rishel – Independent Consultant

Well, this is the same old hand again, when we talk about...when this was prepared on the call was there a thought about the timeframe for accomplishing these?

Again, I'm just going back to what do we need to or what can be done in the timeframe when people are still struggling with Meaningful Use Stage 2 conformance versus what could improve Meaningful Use Stage 3?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, I think the goal...I'll speak maybe out of turn, I would just say I think the general feeling was how can we do this in a way to help with Meaningful Use 2 as opposed to add another burden. I think this is intended to remove some of the current challenges and frustrations that provider groups are facing right now.

Wes Rishel – Independent Consultant

Okay, so the implementation phrase, implementation expectation is to do what we can sooner as opposed to do more perfect, pardon the expression, later.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I would love to hear consensus of this Workgroup but I think what we heard was this is an urgent problem that needs an emergent solution and this is around what can we do practically to eliminate problems in the near-term and I don't think we want to limit ourselves to one shot at this problem, I think it's a series of potentially iterative shots...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Or, you know, we'll come back to it again, but I think we heard loud and clear that, you know, Meaningful Use Stage 2 interoperability is really struggling because of the inability of clinical groups to use these materials effectively and we may have the problem of where people are just, you know, refusing to participate which I think is really a challenge.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Cris?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Liz, what do you want to say?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I was going to say, Cris and Wes and all, I think I agree with what you said Cris and I do think it's going to be an iterative sort of approach, what I would ask all of us is in making a recommendation to the Standards Committee certainly it is within our purview to make a recommendation that we take a look at the standards and begin to work diligently and, you know, with some urgency on fixing it.

I guess I struggle because to not say...we're not in power to say stop requiring it, we all know it needs to be required to move forward. I don't know if there is any opportunity to ask for some leniency while we fix it, you know, I'm not sure Cris and the Workgroup, I do know that just like everyone on this phone has expressed certainly across, you know, kind of the work environments that I cross which is large the very same things that are being said on this phone are said on a daily basis by providers, you know, across the United States and all the places where we work and so I know the need is real and like Cris I have huge concerns that people will just stop if they think that there is not hope on the horizon and I don't know...and I think we can provide hope by getting the standards re-looked at but with no timeframes or relief I'm kind of at a loss, you know, as to what we're offering.

Take is one step at a time, the first thing you say is we've got to work on this, it's not working, how fast and furious can we work and is ONC...would they entertain the concept that we could begin to get this out in sort of stages, I think the question then becomes if we put it out in pieces, stages, phases, however you want to, you know, put words around it, what happens to certification?

Unfortunately, there is always a sort of domino effect because today the C-CDA that's in existence as described is what is in our certified products and we can go...I don't have to explain it beyond that you all know what the dominos that fall from that, if we make changes, are.

So, lots of ideas but I think the concepts are right, I think the usability/use of is very clear, the recommendations are strong but is there an opportunity to also kind of answer Wes's question which is this going to be iterative and how are we going to build the timeline that allows us to get the work done and not take people out of the running for Stage 2, you know, attestation.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah, so this is Dave Kates, I mean, I think those are both considerations that we need to be cognizant of and so...like I am confident, present company notwithstanding but speaking for myself, that there are smarter people out there in the community that can think through with those constraints, you know, we've got a set of MU2 compliant products out in the marketplace what's an incremental thing that we can do to solve this emergent problem and then what are things that we might contemplate for MU3 for, you know, some of the broader challenges that we face and just put it out there not necessarily be constrained by what we can think to solve but recognize that those are considerations that we need to charge some of these other Tiger Teams and Task Forces and whatnot to address.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right and that's well said, David and I think that's where I don't know whether in the recommendations and I'm asking the Workgroup, Cris and so on, is that not something we might want to put in the recommendation that there might be an interim step while moving forward.

I mean, so can we make...before we go down the entire glide path can we a couple of stops along the way to begin to provide relief and also frankly to acknowledge the issue.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, this is Cris, I guess I'd want to take just a straw poll of the Workgroup. I guess I would offer up a proposition that this is the case of where, you know, perfect is the enemy of good and that urgent action is urgent improving but not necessarily perfect action is really necessary but we need to continue to revise this.

I think some of these recommendations suggest that, you know, for publishing conformance tools and for providing, you know, ongoing guidance that there would be a series of revisions, you know, of the tools and the guidance that would get better and better over time and would deal with specific issues.

If we're dealing with use cases we're not going to get the use cases right and I use "we" broadly here, use cases right.

So, I'd take a straw poll. Do we assume that these recommendations are around, you know, near-term action to make incremental improvements so as to make interoperability more effective. I just assume that that's the direction we want to go but it would be worthwhile to hear from the group.

So, I'd offer, you know, who is in favor and who wants to speak in sort of opposition to kind of near-term action, where do you think our action should be focused? I'll call names, I'm not sure...

Wes Rishel – Independent Consultant

This is Wes, you know, I'm not afraid.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

As you've proven over and over.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, really...

Wes Rishel – Independent Consultant

Hey, man I'm retired, what can who do to me? I'm going to temporarily at least take a position "I'm against urgency" that will get your attention.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, go for it.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

And the reason is that I don't have a clear understanding of which of these things can be done on an emergent basis and how effective they are if in fact they're iterative. So, from the point-of-view of a vendor or from the point-of-view of an end-user I want to install the project, the project that doesn't need any more changes, in other words, I want to hold off while the vendor iterates, because I don't want to have to iterate my implementation.

From the point-of-view of the vendor I can't just keep doing releases knowing...telling everybody, wait there is going to be another iteration. So if we have a way to characterize iteration differently that's fine.

My second concern is I think that the second bullet, publishing conformance tools is the single most critical thing we can do outside of the area of usability, all right, that is in terms of just getting the technology right, but the fact is that in the absence of perfect specifications, which never happens, he who creates the conformance tool creates the rule and simply having a process where that's seen as fair and useful represents a concern that slows down establishing the conformance tools and finally, who is going to pay for it? I mean...

Joe Heyman, MD – Whittier IPA

Well, we know who is going to pay for it.

Wes Rishel – Independent Consultant

Okay, all right and by that you mean the government?

Joe Heyman, MD – Whittier IPA

I mean the end-user.

Wes Rishel – Independent Consultant

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, the providers are going to pay for it.

Wes Rishel – Independent Consultant

Pay for the conformance tools that the vendors use prior to implementation.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No pay for the...well, we pay for the fees that we get charged, we all know how it works, but it's a good point. I think...

Wes Rishel – Independent Consultant

Well, that just means...what I need to know is a mechanism how it gets funded up front...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Wes Rishel – Independent Consultant

To get to the point where it can charge fees...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Wes Rishel – Independent Consultant

With all of the government...I mean, really...I'm for, but I took against because I feel like simply saying "I'm for this stuff" without knowing more detail was potentially too easy.

Joe Heyman, MD – Whittier IPA

This is Joe...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, maybe the word “urgent” is inappropriate Wes. I guess my question is, you know, are we looking at near-term action or long-term action, I didn’t mean to step on Joe’s toes, but I’m interested to hear from you, Wes, so...

Wes Rishel – Independent Consultant

Oh, I think...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Do you think we should wait a year for or it?

Wes Rishel – Independent Consultant

Emergent is better than urgent at this point I would say.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, fair point. Joe, sorry, I stepped on your toes?

Joe Heyman, MD – Whittier IPA

No problem, I was going to say, there might be some things that could be done right away without being too much of an imposition and other things that might wait. And what I’m thinking about is the issues where people are...vendors are allowed to use three different standards to put something in place. If you suddenly take away one of those standards that maybe a big costly thing for them even though it would be better if they were probably constrained to one standard.

On the other hand the issue of, and it’s way above my head, but the issue of the null versus having a statement there that indicates that there really is no information, you know, that the patient doesn’t have a problem. I don’t know how to describe that but I hope you know what I’m talking about. That issue, it seems to me, could be handled relatively quickly but maybe I’m just naïve.

So, if we could sort of figure out what issues could be handled quickly that would make a difference and which issues really need a lot of work that should wait that seems to me to be the most rationale way of handling this but I don’t know how to do that because it’s above my pay grade.

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

So, this is Micky and I don’t know I might be confusing Workgroups so I apologize, I’m sure that happens to a lot of you on occasion, but I thought one of the things that we heard from the testimony was a pretty clear indication from almost all of the presenters, me included, that, you know, this can’t be an either/or that there is some immediate stuff that has to happen with refining the C-CDAs while we have the long-term plan of hopefully a transition to FHIR or something that is going to be more of the long-term solution.

So, in terms of the near-term, you know, I just wonder if what we’re trying to do is when we say, you know, to some of the practical points that Wes is raising, you know, is this really a question of, you know, is the S&I Framework the place where this kind of further enrichment of, you know, identification of what are the key issues so if it’s that what we need is a smaller set of well-defined templates, C-CDA templates that can be constrained in a way that is practical that identify the predominate types of use cases that people need to be able to have enabled for their just being able to get through Meaningful Use Stage 2 and conducting, you know, proper clinical care that that’s what, you know, sort of the focus is.

And, you know, where does that happen, is the S&I Framework the appropriate place for that to happen, can that up with timely and practical sort of solutions to a process that is, you know, refining these to get these out into market in incremental steps, now how vendors do that is, you know, a little bit of a challenge, but it seems like these aren’t, you know, full version upgrades these are the kinds of normal, you know, sort of, you know, versioning and upgrading that happens with all of these vendor solutions. So, I mean, is that really the question that we’re after here?

Wes Rishel – Independent Consultant

This is Wes, Micky another way of asking your question, if you accept a friendly amendment is can we sort out the issues into groups that are addressed in different ways. So, for example, issues having to do with technical ambiguities or errors in specifications it seems like the S&I Framework is right there.

When it comes to issues involving the usability of the produced document by a clinician it's not clear to me that that's an area that the industry would trust to the S&I Framework the skill sets and so forth seem to be different.

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

Right, right, right, right and it maybe that, you know, and this is just sort of a question of philosophy or something how we deal with those two things, one is making it consumable is sort of a part of a standards process whereas usability, you know, becomes sort of more of a market process. Meaning that market feedback starts to inform that more but if it is at least...I can't figure out whether it's usable until its consumable.

Wes Rishel – Independent Consultant

Right.

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

And perhaps part of the problem we're dealing with is that so much isn't consumable that we can't even figure out what is usable or not.

Wes Rishel – Independent Consultant

I would...so by consumable we mean technically consumable?

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

Yes, yes exactly.

Wes Rishel – Independent Consultant

And I would agree that there is almost a logical step. I'm just taking to heart Liz's concerns that we're facing a provider rebellion.

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

Yeah, yeah I have one question of market experience on that, my sense is...and, you know, Liz you're close to it from, you know, being as a provider organization, so maybe I'm, you know, only getting sort of a biased view of the market. But it maybe that, you know, this issue of the usability of C-CDAs is a big barrier to people actually deciding on whether they're going to continue with Meaningful Use or not.

But, from what I'm seeing there is a little bit more of a...it's not, you know, so sort of stark in that way although, you know, it's just as insidious or it is more insidious because it's not, you know, sort of recognized which is that it creates a situation where Meaningful Use is purely a check the box and so we're seeing, you know, lots of places where people are sending C-CDAs and receiving organizations are saying "yes I'm getting them and I'm basically deleting them, because I have no way to consume them."

So, we're continuing forward with Meaningful Use and we're being good recipients but we're actually doing nothing with them, literally nothing.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right that's the issue Micky.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, thank you for that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's extremely well put.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So the question that I guess I've got is let me restate my comments on urgent and so on, I'll take the Tripathi framework, are there things we can do to solve that problem around Meaningful Use 2 is that what our recommendation is while also saying there is a second track around either broad improvement to C-CDA or even replacement of C-CDA with something like FHIR?

Clearly those two things need to be separated, right, there is no way we're going either overhaul a standard or replace it with a new one in the near-term and if we do it would cause even more chaos to the industry.

But, you know, should we wait until that perfect day or should we urge improvements to C-CDA now so we can address that problem and I guess I'd go on a limb and make the case to say we should have a two-track approach here.

David Kates – Senior Vice President Clinical Strategy – NaviNet

So, Cris, it's Dave Kates, agree that there is an urgency and we're hearing, you know, in the community some of the pushback as a result of the non-conformance or lack of interoperability. And I think again identifying those things where it may be simply a question of the conformance testing on specifications were vague or not explicit enough and so we might even solicit input from vendors and whatnot. So, there may be a category of things where there is variability just because there was a lack of specificity those seem like low hanging fruit and/or that are minimally disruptive in a dot release of a product to meet a revision of Meaningful Use 2 that can solve, you know, an 80/20 that might be out there. I don't know what those are but I think if we frame it appropriately to solve the main thing where what Micky just referred to that the EMR vendors in order to get certification produce these C-CDAs but they may be non-used and/or they may be causing aggravation in the community because they're just flying around without any application that, you know, figure out some solvable problems that fit within the constraints we just said that it can't be disruptive it's got to be an incremental approach and perfect is the enemy of good enough and frame it that way.

Joe Heyman, MD – Whittier IPA

This is Joe, I just want to say that I think that obviously Meaningful Use is important but I think that the aim for this should not be Meaningful Use it should be improving care and leaving Meaningful Use out of it.

I just, I think, Meaningful Use I'm sure has done a lot of important, wonderful things but it also has made things very unusable and I think that if you keep aiming at Meaningful Use instead of at improving care and usability in the long run we're going to lose.

Wes Rishel – Independent Consultant

Joe...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, Joe...go ahead Wes.

Wes Rishel – Independent Consultant

Let's say first of all, you know, that is so true that I think it was the 11th thing Moses brought down from the mountain, but what I'm wondering is if we don't use the so called levers associated with Meaningful Use will anything happen.

Joe Heyman, MD – Whittier IPA

Well, that's a good question.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, what I was going to...

Joe Heyman, MD – Whittier IPA

But, can I just...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Joe Heyman, MD – Whittier IPA

Before you say anything Liz...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Go ahead.

Joe Heyman, MD – Whittier IPA

When I first got on the call I thought Wes was referring to an eHIE meeting last week of the Connecting Communities Workgroup where everybody was in a huge hurry to fix this, I mean, a major feeling at the end of the call that this problem with C-CDAs is the biggest problem in the history and must be fixed immediately.

And so I actually suggested that they get on these calls and listen and then at the end we'll see whether anybody has during the public comment part have their say, but that was more about care than it was about Meaningful Use. Now I'll shut up.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Cris, I'm going to...I want to throw something in here. I hear all sides and I think...and certainly we are now hearing from Karen DeSalvo that we need to start to focus toward the future, but I must tell you that Meaningful Use and the lever is very real, what Wes says is real and would I like to not need that lever, of course, but I think that if we ignore the ramifications it has and we see people, you know, Micky you're right, people are literally receiving them and deleting them and not using them and that's not where we're supposed to be, so the lever of Meaningful Use is simply that you've got it in place, it didn't...that's not really how the lever was supposed to work but it is. So, somehow Cris we have to find a happy medium...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Where we focus on what we want be we don't ignore the inevitable which is the Meaningful Use even as the incentive dollars are beginning to come to an end and we're moving to what I call the penalty phase it's still very real.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, this is Cris again, going out on yet another limb and when you hear a thud you'll know why, but, you know, I guess I've got a view-point here that we are here to advise ONC and if ONC's view-point is that the domain extends into areas other than Meaningful Use that's fine and we can take that on.

And I also understand how some other things specifically things that will help accelerate interoperability are a high priority for ONC right now and I can certainly, as a member of this FACA, get behind that. At the same time those things may be propulsive but right now Meaningful Use Stage 2 is an anchor and it's holding the industry back and people have concerns about the rocks ahead of Meaningful Use Stage 3.

And even though there may be other levers to pull and other roads to go down that's all promising and good but if we don't fix people's deep frustration and concern about what they have to do with MU2 and the, you know, potential cynicism of, you know, I'm conforming but I'm not conforming that Micky described so vividly, you know, we're just going to get anywhere.

So, I would offer up again the proposition to say, we can frame this however we want to but I think we have a need to do what we can to make interoperability under Meaningful Use 2 as written as successful as possible and the defects of the C-CDA are clearly getting in the way.

I'm all in favor of adding a second, you know, track to help us look for a, you know, different pathway that is more promising, but I think if we don't help solve the C-CDA problem now, you know, in whatever iterative or near-term way possible there may not be a second road. I think it gives fuel to the second if we can do something on C-CDA.

So, I hope our Workgroup will take the position that we can find near-term action which is practical, which is non-disruptive to the industry and which helps improve interoperability using C-CDAs. I guess, I'm asking...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Does that...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Does anyone that's not something we should do as part of a broader program?

Joe Heyman, MD – Whittier IPA

Actually, I think that's perfect and you didn't mention Meaningful Use in that at all you know.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right and I would say I agree with that Cris and I do think though it needs to be on the recommendations page because although we've certainly made some, I think, very appropriate recommendations there is nothing about when here.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Nothing about what?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

When. I mean, to me what's missing from the recommendations page is a recommendation to do just what you said very eloquently, you know, this is not...somehow we need to create that and we've had many varying opinions which is great, some kind of sense of urgency, because I think what Joe was talking about in terms of not necessarily absolutely tethering it to MU I still think we need to put in the recommendation this is not something we want to be talking about for the first time next summer.

Joe Heyman, MD – Whittier IPA

I agree with that by the way.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Joe Heyman, MD – Whittier IPA

I mean, I'm interested in doing it as quickly as possible I just think Meaningful Use is an artificial construction that is going to go away eventually.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Joe Heyman, MD – Whittier IPA

But taking care of patients that is going to be here forever. And people were talking about HIEs 10, 15, 20 years ago before there was ever any Meaningful Use.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, I...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's right and here we are at the cusp of maybe making them actionable and we're grinding on the unusability of these documents.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I love it, Micky that's very exciting, huh? I don't know if he is still with us.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think Micky needed to drop, but I'd love to hear from those who are actually engaged in this day-to-day, you know, maybe we're too broad here, but I like the idea of having some sort of call to action about near-term and long-term action.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And I guess I'm looking to see if that's something that this Workgroup wants to opine on, I would suggest it, but looking for consensus.

Joe Heyman, MD – Whittier IPA

I think you had consensus on that eloquent statement you made somebody just needs to listen to the transcript again...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Joe Heyman, MD – Whittier IPA

And copy it down exactly.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

There you go Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'd like to hear from Dave, John anybody else from sort of the practical or vendor community, of course anyone else, but...

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah, I think you stated it well, so I don't have much to add. I think we should push in the manner that you just described and it is...I mean, it's a combination of, you know, we've created this, interoperability was one of the tenants of Meaningful Use Stage 2 and in practice it's not usable, so, I mean, I think you said it well.

I mean, it's an anchor and there are head winds ahead of us so I think it's something urgent that we need to address both in terms of patient care and all the things that Joe described because it's not just to check a box it's for purposes of continuity of care, for transitions of care and other use cases. I mean, I couldn't support it more.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, this is John; I would agree I don't know that I have much to add to it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, Liz and others I think the issue is, do we want or does this seem like a good summary of the actions to be taken? And if so what's our next step with respect to partnering potentially with another Standards Committee Workgroup...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, I...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That was what we discussed on the planning phone call the other day. If there are people who have suggestions to improve on it that's great, but I would suggest we work jointly with one of the other Standards Workgroups.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, yeah, I would say, given this conversation today what we ought to do is we ought to add the call to action component that you discussed and I think we ought to change the fourth bullet on the recommendations and in lieu of saying "proposed charging" what if we said "proposed collaborating with another group" and then let the conversation take its natural course with the Standards Committee and/or have, you know, John, you know, guide us in some way.

I mean, to me those are the two changes I'd make as a recommendation to the recommendations. How about everybody else?

Wes Rishel – Independent Consultant

This is Wes, I'm not sure it's one other committee I just think that there are technological issues and there are user issues that apply.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right that's a good point.

Wes Rishel – Independent Consultant

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, maybe we...yeah, we need to identify what...

Wes Rishel – Independent Consultant

Committee...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Wes Rishel – Independent Consultant

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

We need to identify what Workgroups within the new established infrastructure need to become engaged in this and whatever division of the part which Wes is very adequately talking about needs to be assigned. I mean, and again, I think Cris your point of making sure the Implementation Workgroup and what we've talked about in the past is making sure that we keep our feet on the ground.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right, so, I guess that's part of the reason I'm speaking up with so much kind of energy today is it feels to me as though we ought to try to do the work if we can to set some sort of timeline or deadline, or aspirations around when we want to try and get this work done.

If we turn it over to other Workgroups that is great and they will make progress, but, you know, is there a natural point that anyone can suggest of maybe it's a discussion in the next group, would we try to set some milestones or deadlines for when we would want to get to a next iteration on some of this work.

I frankly, don't know what those deadlines would be we probably need to get input from many. I think there are some folks on this call who might be able to suggest now or on further reflection when should we try to get to version next.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Oh, wow.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Is it first quarter of next year, second quarter of next year, third quarter of next year? I don't think its third or fourth quarter this year, maybe it is.

Joe Heyman, MD – Whittier IPA

Doesn't it matter what it is, which of these things you're going to be able to do...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

Joe Heyman, MD – Whittier IPA

In a certain period of time?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, there is a...yeah, there is a concept, maybe the concept comes back that as we dissect this a little bit and come up with components that people can answer that we ask that they bring back a timeline or something to the standards group or to the Standards Committee and/or the Workgroup not that we're...or maybe it's the Steering Committee, remember John is going to have a Steering Committee that sits over all of this and maybe by bringing it there than we can kind of look at the date, you know, kind of look at the global picture and the timelines and like Joe was suggesting then we can see if a critical component is being proposed is taking...I don't know pick your flavor, a year and we know that if we can't even get to a discussion in a year that the following of, you know, the timeline expands from there will be several years before it's actually in code.

I think that's...so maybe the request is a recommendation that as the components are determined that, you know, I don't want to say aggressive, but clear timelines are assigned is that too wishy-washy?

Wes Rishel – Independent Consultant

I think we need timelines based both on what can be done in a timeframe and what are the consequences of not doing something and this is where, you know, I find myself continually unable to live up to Joe's standard here, but this is where I think the incentives and deadlines around Stage 2 do enable us to get attention.

It may in fact be that some of the responses if the situation is proper to assess is some, you know, new guidance with regards to Stage 2. I don't know and I'm not proposing that and please don't quote me on that, but I think if we identify the consequences vis-à-vis conformance and penalties, and bonuses in Stage 2 that will guide us towards is this something we need to do, you know, urgent and necessarily messy versus do a better job and see the industry improve more in the long-term.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Yeah, so this is Dave, I mean, I think maybe there is some, you know, physics here that can help guide or constrain the timelines that there are some things that we can frame the problem or identify like Wes said, you know, those things that are having the most impact that require the most urgent need and then I'm thinking through the whole bureaucracy in terms of if we do in fact, counter to Joe's recommendation, if we do leverage Meaningful Use then there is, you know, NRPMs and whatever regulatory mechanics that need to happen and so if we have a process and set timeframes that say we frame it and come up with a set of recommendations over the course of the remainder of this year and in parallel, you know, as urgently or as realistically as possible to find what levers we can move or what efforts we want to focus on around tools, around refinements to what's already in Meaningful Use Stage 2 and have something out that it can get into that pipeline and then just realistically look at what the timing is that results.

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

Cris and Liz, this is John Derr, just to put a little thing in here, you know, I don't disagree with anything anyone said and the vendors in our sector are, you know, working to move from the CCD to the C-CDA.

And one other thing to happen in the S&I Framework Doctor's Terry O'Malley and Larry Garber, you know, were working on a longitudinal care committee and came up and I don't know whether this is germane in this conversation or not, but they looked at the number of data elements and the templates that are needed for longitudinal care that's a patient's longitude not just transfer from one care setting to the other and it was almost twice as many data elements required and also there were things like 30% of the templates were missing.

So, as we look at...I agree we've got to solve this right now, but let's not...let's make sure we look at the future so we just don't band-aid a problem.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, Liz, just to get practical we're going to want to wrap this meeting up and go to public comment reasonably soon here. We have an obligation to do a presentation. We have an opportunity to do a presentation to the Standards Committee next Wednesday.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I would...I think we should bring to that committee a fairly bold statement about what we want to do and I think we're getting close here around what the recommendation is and we can look for input at that point. I think we also can get input from ONC obviously after this call about what we should frame up based on their view-points of what's practical.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I agree and I think other than adding a timeframe we're very close and we could circulate, you know, kind of the "final deck" hopefully by the end of the week so that we can get input from the Workgroup if they chose something that they have concerns about. Are you good with that?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I just think we ought to have some sort of, you know, joint effort between at least two of the Workgroups, but, you know, I also think we don't want to burden this down with a whole lot of bureaucracy and a lot of meetings.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

It would be great if we could get to something that's more Tiger Team and less, you know, joint Workgroup. But if there is a way that we can get to a recommendation around near-term improvements in the C-CDA taking into account all of the potential solutions and recommendations that are in this deck with the goal of delivering those, you know, with all due speed in the order in which they can be delivered we should do so.

I think, we also need to find what's the venue for actually, you know, doing these conformance tool testing, we've not discussed is that S&I Framework, is that some other industry group that wants to step into this, we haven't defined those options yet.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And do we need to define the options or do we need to look to the Standards Committee, ONC and the like to make suggestions, what do you think, Cris?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I know I was part of a small Workgroup that was or a small sort of focus group that was assembled by ONC to look at interoperability more broadly, so I know that there is some thinking being done at ONC around where should these kinds of issues be raised and addressed. Micky was also part of one of those discussions as well. I frankly think we should get some input from ONC at this point Liz before we...

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

From my perspective as a FACA member I'm somewhat indifferent around where that...what the venue or convening group is, but I think there should be one. And there as some discussion in that meeting around S&I Framework versus sort of public/private collaborative for a number of these efforts.

So, maybe we take this a little bit off line to get some dialogue with ONC staff and then circulate recommendations to this Workgroup before we take it to the whole committee on the 20th. How does that sound?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

That works for me.

Joe Heyman, MD – Whittier IPA

That sounds good.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

That sounds good.

Joe Heyman, MD – Whittier IPA

Cris, I was just going to say, you know, I would go along with trying to find a bold statement, so when you're off line and you're doing all this if you can figure out a way to make it bold that's great.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I think Joe that's a good point and we certainly have done that before and, you know, I think it's effective people really I think are appreciative of simply saying what it is you need and then the response to that can be as it will be.

I mean, you know, I think otherwise they kind of...if we don't come up with a statement that's bold then sometimes people have more questions and they were kind wondering what it is you wanted. Cris and I have not been accused of that too for example, that's a nice statement for the week.

I think we know where we need to go. I know that we're at the end of the hour. I'm thinking that if we don't have a lot more we really do need to go to public comment. Anybody from the Workgroup, we certainly have gotten a lot of really helpful input as always and wisdom, are we good to go? Should we pause just a minute?

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

Liz and Cris, this is Michelle, I just want to note that as you referenced we're working to restructure all the Workgroups and once we send around and get final recommendations that are shared at the August 20th meeting this will be the last official meeting of the Implementation Workgroup and then we will transition to a new Workgroup that will be the Implementation, Certification and Testing Workgroup, and so all future meetings will be cancelled for this group, I just want to make sure that everybody is aware and thank everyone for their participation in this group.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Good point, good point.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And absolutely, thank you.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thank you for that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes, let's go ahead and go to public comment then so we can sort of keep people on time and we will certainly be circulating, Cris, right recommendations...our final deck which will be very simple and we will work, Joe, to come up with our statement so that it's clear what the need is.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sounds right.

Public Comment

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

Okay, operator can you please open the lines for public comment?

Caitlin Collins – Junior Project Manager – Altarum Institute

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

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

Hi, thanks to this group for holding hearings and for its summary. I'd like to elaborate on your first recommendation; the issues thus far in consuming from C-CDA are not surprising because there has been no regulatory requirement or guidance on consuming data either for vendors or providers.

In MU2 vendors have only the clinical information reconciliation objective to import and reconcile three, not 17, types of data, problems, medications and allergies. So, while standards exist to create these documents there are no standards named for consumption or reconciliation. So, any absence for guidance vendors are on their own.

And furthermore MU2 has no usage requirement for hospitals or EPs to do clinical information reconciliation except for medications. So, of course experience is going to be very limited. While there is one standard I know of, IHE reconciliation profile, that deals with reconciliation of medications, problems and allergies it was not cited and hasn't had much experience.

So, since there is a lack of clear standards and tools for vendors to test and in interoperability of C-CDAs in MU2, and there is no incentive for providers to even try reconciliation, I believe the recommendation needs to take that fact into account.

I believe that the industry needs to focus on what needs to be consumed and start by selecting or constraining standards and guidance for what they already have to do, consumption of problems, medications and allergies.

And then subsequently, we could consider expanding to a couple of other types of data such as the results of procedures or vitals, but proceed cautiously until we get it right with the first set of data.

And it's very important, I believe, when discussing consumption to not ignore the challenges of reconciliation. I believe that most if not all clinical data needs a reconciliation process rather than simply being pushed auto-magically into the EHR even with provenance.

Lack of reconciliation would result, I believe, in data redundancy, conflicts, confusion and clutter. So, thank you for the opportunity to comment.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thank you.

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

Thanks everyone.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Thanks everybody have a great day.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

All right, thank you, bye.

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

Bye.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Bye now.