HIT Standards Committee
Consumer Technology Workgroup
Transcript
September 10, 2013

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Consumer Technology Workgroup. This 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 the meeting is being transcribed and recorded. I'll now take roll. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Brian Carter?

Brian Carter – Executive Strategist – Cerner Corporation
Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Arthur Henderson? Brian Ahier? John Ritter? Anshuman Sharma? Susan Hull? Mo Kaushal?

David Harlow, JD, MPH – Principal – The Harlow Group LLC
David Harlow here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
AJ Chen?

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
AJ is here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Tonya Dorsey? John Derr?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Yair Rajwan? Tom Jones? Liz Johnson? Christine Bechtel? Marcia Nizzari?

Marcia Nizzari – Vice President Engineering – PatientsLikeMe
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Fred Trotter?

Fred Trotter – Founder and Healthcare Data Journalist – Not Only Dev
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Russ Leftwich? Holly Miller? David Harlow?

David Harlow, JD, MPH – Principal – The Harlow Group LLC
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Wes Rishel? Susan Woods? Kim Nazi?

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration
I'm here, thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Good morning. Are there ONC staff members on the line?

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor – Office of the National Coordinator
Ellen Makar is here.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Mary Jo Deering is here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Good morning and I will pass it back to you Leslie, thank you.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Thanks, Michelle. So, we've had a few wonderful meetings and heard from a lot of experts. We've heard from our technical expert panel, we've heard from standards experts in care planning and harmonization and patient generated health data, and device data, and we've also discussed some important balance themes.

We should be mindful of balance in every way. We're tasked with some very important work however to answer the question, can standards support the Meaningful Use 3 recommendations for patient generated health data? So we have an important job ahead of us and today what we hope to do is to really get to the meat of the discussion. Next slide.

We'll do an overview and we'll discuss some themes and lessons learned throughout our presentations and then discuss some strawman recommendations. So, what I'd like to do is to go through the slides and if you have a comment on a specific slide like you forgot this or add that please feel free to chime in, but I would like to leave the majority of our time to discussions for recommendations towards the end if that's all right. So, next slide, please.

So, to remind us all of our great team members. Next slide. So our charge is to provide recommendations for standards and interoperability for consumers and patients and our scope is to address issues of portability of patient data access and today we're going to discuss specific items on patient generated health data. Next slide.

So, we ask what standards are needed to support the flow and use of PGHD. We've asked all of our groups that presented to us to answer these questions and provide us important information. We heard about PHRs to EHRs. We've heard about Direct. We've heard about other secure messaging and touched on vocabulary and standards. Next question or next slide, please.

Foundation, we do know that standards to support patient generated health data have already been incorporated in Meaningful Use 2 and we'll discuss those today and we hope to then discuss our recommendations to support Meaningful Use 3. Next slide.

So, we have learned and confirmed what standards there are to support the acceptance of PGHD, what's available now, we have a lot of things still missing and work to do and gaps. We also know that there is a good deal of foundation that we're laying right now for future advance use cases.

We will need to address maturity and adoptability in these standards and look at the future of that maturity and adoptability for 2014 and 2015. Next slide.

So, here is an overview and we'll see some common themes that we've heard and would love to hear your reaction to them. Next slide, please.

So, themes that have been really an anchor for our work is to use or repurpose existing standards where possible. Now, we've also learned that in doing so we inherit the benefits and the problems from a mature standard. We also know that and need to acknowledge that even if a standard is mature in the provider world it's new in the patient world and vice versa could be also held true.

We know that standards can constrain or encourage innovation and that's one of the first areas of balance that we should consider in our recommendations. Next slide.

When presented with information on the HL7 work we were really given the concept that patients are equal care team members and so the approach that team took was to actually modify the header at the HL7 C-CDA document level so that a patient and all of the associated more broad terms, caregiver and such, would be considered at an equal level and help to constrain and define future use cases for the CDA. Next slide.

We also have talked a lot about the consumer friendly standards or provider friendly standards and I'd like to propose that consumer friendly standards should be encouraged and are likely for outbound data from an EHR largely because the patient assumes the risk. We heard from Dixie Baker on the NwHIN standard and the new Blue Button Pull that using FHIR and OAuth 2, and other standards that are very widespread used in the consumer world.

We also know that provider friendly standards are likely for inbound data largely because the provider assumes the risk of accepting that data. And so we may end up with this sort of Ying and Yang that we have recognized today in the Blue Button efforts. We have needs that are very open when something comes outbound. A patient can ask that something be downloaded or viewed or sent to their e-mail address in the clear because it's the patient's choice.

But we also know that as we do transmit in the Blue Button for example that's today going from provider to provider and inheriting all of the security and structure associated with that. So, this is one theme that I think is worth discussing. Next slide, please.

We also heard that harmonization efforts continue and should be encouraged. Russ Leftwich talked to us about what's happening in the care planning and the patient and family roles and that there is also some significant work being done in HL7 for person ID and organization ID's for health professionals, family caregivers, community caregivers and the NPI for health professionals.

So, we have an opportunity to integrate and harmonize this new patient and family roles across a wide variety of standards and Wes talked to us about the DAM being used in HL7 to help do that. Lisa Nelson talked about in the past we looked at how do I do this individual thing and then harmonize it to a greater concept. With the patient's information being included I think it's just the opposite we're actually looking at what can be harmonized with the patient and then how do I do a specific thing?

We also learned that patient participation highlights some overarching collaborative record needs regardless of whether the patient was included or not as we bring together multiple care teams the idea of versioning, provenance, adjudication, reconciliation and harmonization is very much and overarching need for collaborative records and one that is just simply highlighted or exacerbated when we include the patient, so that's a big area of work to do in the future. Next slide.

We also learned there can be some messiness and I think we learned that lesson in the provider world, there is often a need to make things better and we should try to mitigate that messiness with standards, and we should also acknowledge that pilots and menu items in Meaningful Use can be complimentary.

Mature standards used with patients are still new in the workflow and mature standards in consumer world are still new to providers. So, it really is this balance that we have to consider throughout our recommendations. Next slide, please.

We also have learned that the momentum for PGHD is here and growing. Now proprietary systems today that are EHR tethered PHRs are filling some basic needs, however, patient generated data has high needs for interoperability because this data persists in every record although its often been entered by the provider it is, today if it's patient generated data it persists, it's demographics, it's histories, it's medications, goals of care and etcetera.

So, standards and interoperability at the onset of this work will promote collaborative records in the future and help create a structure to increase the usefulness and availability. So, we have a Greenfield ahead and it's an opportunity for us to create a Greenfield of interoperability. Next slide.

We also know that the foundation builds a future. So, today when we look at patient generated health data we're really looking at things that help patients active in care. We're adding that information just the basic information that helps to make sure that the moment in care is the most informed. We add the patient's roles and responsibilities. We have the information.

We heard from the technical expert panel that its safety related, that it's administrative, that both provider initiated and patient initiated, both structured and unstructured. And provide opportunities for device tracking.

We know as we move into care planning we'll look at shared decision making, things that are happening in the home, transitions of care, goals and values and many other things will be part of care planning. And in the future as we see a more collaborative care model we'll see multiple care teams, community support and social support.

So, really starting at the beginning with making sure that patient generated data is aware and known within the care setting, then moving to common understanding and then moving to an environment of sustaining health. Next slide.

So, high value patient generated health data that we heard about. Next slide. Well, we've heard that health related data created and gathered, this is our definition, from patients or their designees to help address a health concern that its broad types of information and the uses are evolving. It could be an observation, a result, a confirmation, a change, a correction, an addition. It's not a new phenomenon; it's just not always been labeled as patient generated health data. So, it's important to understand we're just simply getting the data now from the source. Next slide.

So, we heard from the technical expert panel about safety related values and benefits, medication lists, allergy lists, things like environment as well as drug and nutrition, intolerances and barriers to care. Next slide.

Under the patient and provider care plan that's related we heard patient goals and values, things that support shared decision making, information the provider has requested, we heard that over and over again that there is absolutely no argument when a provider asks for information they want to have that returned back into the record.

The recent changes that might prompt a change or reconsideration of a care plan enables long-term data persistence like advance directives or POLST or enables device and tracking data that's both asynchronous and synchronous, promotes the previous preparation and gathers histories like family and surgical. Next slide.

We also learned that new patient concerns can be an important opportunity for patient generated data, patient reported outcomes and administrative and important data, a patient profile, high impact on care processes, information that has a high impact on efficiencies for providers and convenience for patients that both contributes to the caregiver and the care team and communication preferences can be gathered as well as experience of care. Next slide, please.

We also heard the importance of policies and procedures to reduce burden and risk for everyone and to make sure that we're help to setting mutual expectations for patients and physicians, and staff. One suggestion is that the great work that the ONC did on their notice of privacy is could there be an opportunity for patient generated health data model as well in policies and procedures. So, that was a good opportunity and suggestion. Next slide, please.

So, the technical expert panel talked to us about their conclusions, it's an opportunity to capture needed information for use during care with potential cost savings and improvements in quality, care coordination and patient engagement. It's valuable for many reasons including fostering learning, giving people a better opportunity to assist in care, to coordinate multiple care team members. We heard from someone that the average Medicare patient has 14 providers. A provider gets more accurate information; we heard that from Dartmouth and Geisinger.

And then providers can assess information that impacts care decisions, can help avoid medical errors and reduce the data collection burden for providers. This was one area that I think in a separate group we heard was in the Implementation Workgroup, I'm sorry I don't think our team was involved, but there was overarching concern about this new collection of data that might be required for the research community and that how it could be helped by having patient generated health data. Next slide, please.

So, balance is a theme everywhere. We heard from Liz that one menu item is 100% for the HIT vendors to choose. Can we get you guys to mute? Okay. We also heard that there is – from Wes that there are provider standards and there are consumer products and each have grown from a different place, and putting too much specificity on provider standards could stifle consumer products but also putting too much emphasis on consumer products could stifle provider use because of fear of security, privacy and other regulatory constraints.

There is also a balance between getting information for the episodic need and the knowledge acquisition to collaborative care which is in the future, which is many different parties involved in care planning. Next slide, please.

The maturity index that we looked at from the NwHIN Team, we have to acknowledge that mature standards are still new to the patient, provider and workflow even when used for the patient. And some of our work will be creating these maturity criteria for our final recommendations. Next slide.

So, given that there is really a continuum of patient generated health data from messaging to structured information like a questionnaire to unstructured or narrative and hybrid information. There is device data. There are plans of care and collaborative care planning and the difference of those, we heard from Russ and the long-term or excuse me the longitudinal care team is that a plan of care can be many, it might be a patient with diabetes who has a plan of care on my lesion management but I have an overall care planning that might be done that's related to the fact that I have multiple chronic diseases that need to be coordinated across many care settings. So, I distinguish those two.

We also know that the patient and the providers of record cross over all areas, we need to know that, those are standards, the roles, the responsibilities and the providers of records, the participants, the care team members need to cross over all areas. And as we move across that continuum and get to things like devices we now are adding home care, potentially hospice, guardians, parents, legal other representatives. So, our participants grow as we move from left to right.

In plans of care we're adding non-traditional care givers, long-term post-acute care and other and as we move into collaborative care planning the needs for community and social support are increased. And these different players might enter at different times this is simply a strawman attempt to say that as we move forward in patient generated health data to much more collaboration the roles and the participants increase. Next slide.

The features that we've heard in each of these areas, these are some of the areas of high value patient generated data that we talked about. In messaging we heard that it needs to be secure and private both non-tethered as well as tethered with or without attachment. That in structured questionnaires things like histories, medications, personal profiles, pre-visit decision aids, smoking status, screening, problems, symptoms, consent, participants, HRAs, HCAPS, experience of care, POLST and advance directives, nutrition, allergies, amendments to the records, barriers to care, preferences and self-reported outcomes were all opportunities that could be met within a questionnaire structure.

As we move to unstructured and narrative or hybrid we have really the consumer centric world and that's things like it could be Word or Excel, or any type of information that the patient is generating in terms and technologies that they use to a hybrid approach that could be a structured template with unstructured narrative. So, it might be for instance a very structured consolidated CDA document with internally an open area for a narrative.

In device data we heard that there is really two schools almost, the provider directed device that might be biometric in telemetry or repositories of data that is something that perhaps that provider is sending home with a patient. We would expect that to be a very provider centric standard, but consumer directed and consumer products are still largely ill-defined in terms of standards that can be used and so we looked at perhaps separating these two ideas.

In plans of care we looked at both episodic and heard about chronic care conditions and these are plans of care that are very siloed. They are one or many. We also know that as we look at plans of care things like versioning and reconciliation, and harmonization start to appear. And in collaborative care planning it's much more holistic and integrative, horizontal for a word; you might want to look across a particular plan across multiple care plans or multiple care settings. So, there are multiple care plans and then we get into things like governance and curating.

So, whereas reconciliation and harmonization, and versioning really looks at more of an asynchronous or two-parties, binary perhaps or when we move into collaborative care that notion of how do we govern the use of this data, how do we curate because it's not necessarily a reconciliation that's required but a consideration of all parties participation and someone might act in a curating role. Next slide, please.

So some of the standards that could be applied in this, we would assume the common Meaningful Use dataset for standards and vocabulary, but in messaging we heard about Direct and SAML, and hData, and OAuth 2, and a RESTful approach. In the structured and unstructured data we heard a lot about the HL7 consolidated CDA work for PGHD and we also heard about FHIR as an emerging standard.

In the device data we heard a lot using also in supporting in the HL7 consolidated CDA, Direct for transport, there is also FDA standards for use in things like mobile devices and actual medical devices. We heard a good deal from Continua who is currently using the IEEE and the Bluetooth, and NFC, and ZigBee and USB, and HL7, and the list goes on.

And then in care planning we heard about HL7 the care plan within the consolidated CDA. And we also heard the vocabularies that are current being used are SNOMED CT and LOINC. So, I'm going to go through a couple more slides and then open this up. So, the Next slide, please.

And this is where I think we'll have a lot of discussion. So, the yellow highlight is the possibilities for Meaningful Use 3 that we could be ready and we can be ready to provide patient providers of records and care team. There has been good work done within HL7 in the patient generated care team and in the care team roster that helps to identify this data. But, we're not necessarily ready yet in other areas. Next slide, please.

On the Meaningful Use 3 ready I think the secure messaging and use of Direct has been outlined already in Meaningful Use 2 and we hope to expand on that. In the structured data in the questionnaire because of the approach the HL7 team is taking there is really a high opportunity to use the templates that have been developed and to use the standard already named in Meaningful Use, in the consolidated CDA, to do these questionnaire forms and to also support a hybrid approach.

We don't yet have opportunities for the consumer centric types of unstructured data yet but I think that will be evolving. And in the device data we have opportunities really in that provider directed world where devices have the opportunity to integrate with the record. And still very much a lot of work to be done still in plan of care, reconciliation, harmonization and multiple care plans.

However, having the participants identified as we mentioned in the slide previously would get us a long way to help to support care planning, and the fact that the HL7 patient generated health data team is using the consolidated CDA and so is the care planning team we have opportunity for continued harmonization and signals to the future. Next slide, please.

So, our expectation is that we can improve care by using patient generated health data. It can improve accuracy. We've got some opportunities for confusion and angst but we also know that it can empower and engage patients and I'm often struck by something that Dr. Mostashari said and that's "isn't it better to know" and I think that reminds us all that the patients really are the ones with the most at stake.

So, with that I would like to open it up to comments, questions and discussion, and let's first start with what's missing in the slides that people think we need to add or I've forgotten and then we'll move to the actual recommendations themselves. Comments from the team?

Brian Carter – Executive Strategist – Cerner Corporation
This is Brian from my perspective it feels like it's complete.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
I didn't hear you?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC
This is John Derr; I think you did a great job on putting all this together. There are a few little things that I'll just send you in an e-mail.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
Okay.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC
But, I think overall it's really great.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Any other comments from the group?

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration
This is Kim and again I'm amazed at how you kind of synthesized and reflected all of the rich discussions. So, I think it's excellent. I'm still thinking about patient preferences and I know that you captured the idea of patient preferences but I'm still thinking about patient preferences for kind of granularity in sharing data and I'm not sure where that fits and maybe it's kind of one –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Actually, that's prefect, no, if you could go back Caitlin to the slide with the most yellow on it. A couple of slides back. So, actually, one more, yeah. So, we had preferences there and I think that there are goals of care in the care plan CDA. So, I think we have an opportunity to expand on that and get to more detail there.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration
Okay, thank you, thank you.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Because, I think Wes talked or excuse me, Russ talked a lot about the work when he brought us up-to-date on the care planning and the areas where I think we can tap into early our goals of care, preferences, care team members and that helps to feed these future use cases.

Kim Nazi, PhD, FACHE – Management Analyst – Veterans Health Administration
Right, right.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Leslie?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Other comments? Yes?

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Sure, Leslie, this is John Ritter, hi.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Hi.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Really great presentation bringing this all together. I see that we've concentrated here on the information related standards and how we get and share the information. My question is what about the functionality related standards if systems are to be certified not the information to be certified but if systems are to be certified –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
In the US shouldn't they be standards-based.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
And shouldn't we name a personal health record-based functional model standard on which to base certification conformance criteria for certification?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
I think we can and thank you for bringing that up.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Sure.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
In the actual Meaningful Use standard common dataset we get to some of that very specific and I started to write all the 170.20/e's and thought that might not be useful yet, but we will try to reconcile that. The question comes up on I think the – with regard to specifically the PHR recommendations and John you can probably answer this, to what level has there been harmonization between the PHR specifications, the work in the care plan and the HL7 consolidated CDA, and the Meaningful Use common dataset? So, the DAM as well as the others? Can you comment on that?

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Sure that's easy to answer. The personal health record system functional model describes what systems can and should do and it should do so in an architecturally neutral manner and it should do so in an informationally neutral manner, that gives the vendors the freedom, everyone the freedom to choose a standards that works that meets the need, but it provides the ability to test the system to see if it does what it intends to do. So, you have –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
So, in that case –

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Go ahead?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
In that case then John would the – it seems to me we've got the what and the how and that the PHR functional model helps to define the what.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Nope, the how, no the how.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
And the standards do the how, okay.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
No, no the data defines what it is like what is a field for age.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
What is a field for a name, so now you know what it is, but what do you do with the age? What do you do with the name? So, the functional model defines what can and should be done by the system with the information. Can and should it be shared or should it be encrypted? Should the members of the care team get the information? If a person gets married and the name changes is that important to the members of the care team? So, the functional model helps define and put constraints on the use of what by declaring in a standards-based manner how.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
So, that would be I think a really important concept for the group in our harmonization efforts to say, what can we learn from these compatible efforts going on, from the PHR functional model to the care plan, to the actual consolidated CDA because remember what we're talking about today is how an EHR receives the patient generated health data so it is going to be very specific to the how or the actual element or structure. So, I think it's very important that we look at your suggestion perhaps as a next work effort in the fall. I think that would be some interesting work. Other comments and considerations?

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
Leslie, this is –

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
So, I think – go ahead?

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
This is Sue Woods, thank you, nice job. I didn't have the slides in front of me as I was listening, a comment about I think one of – the big cause of angst for clinicians is the potential tsunami of additional information that needs to get reviewed and I think there should be something – and again, you know, this is a brave new world I feel like a cowboy in the wild west here.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yeah.

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
There are some assumptions I think that we shouldn't make. For example not all data needs to be – maybe not all data needs to be reviewed, the data is also for the purpose of the patient and their monitoring and back end functionality could be automated to notify the patient user. So, and I'm not sure I heard that, it might be in your slides, but I didn't hear it.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
So, I think we – I've tried to reference the Blue Button Pull for patient update of information and outbound but the inbound information can you elaborate on that a little bit Sue? Because, I think you're right the angst that we heard was a tsunami of information.

The testimony received though, that was part of the technical expert panel, reflected that it didn't happen and one of the reasons I think it was that John Wall talked about was that in the use of the structured questionnaire and the idea of a patient response where something is asked of a patient and the patient responds it's all meaningful, it's all good, everybody wants that.

And so that's why I really highlighted the structured questionnaire as ready for my primetime, because it is much more in response to a provider. So, did I capture it?

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
So, I think it was Chuck who, you know, said solicited data, so – right in the instance of, you know, I want you to – we want you to monitor x, y and z, and send us the information, but, you know, there also needs to be opportunities for patients to push data.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
And then, you know, I think we have three kind of models one is that we're asking for specific things and then we're getting responses where patients are pushing information when they've – you know, secure message is the perfect example of –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right.

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
You know, patient entered data at the time the patient wants it, right? So, but there is a backend assumption that that's going to get addressed.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right.

Susan H. Woods, MD, MPH – Director of Patient Experience, Connected Health Office– Veterans Health Administration
And then there is also this other – and it's, you know, gray area and maybe it's not patient generated data if the assumption is that patients are monitoring or collecting data and not necessarily pushing it and I think the question is well then do we care about that? You know, I mean we –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
And I think the question to ask is who is the "we" because if it's the provider, if it's the patient initiated data or the patient collected data at some point in time we all have to – whose judgment are we – we have to reflect the patient's judgment right? We can't mandate the patient share.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Leslie and Sue, this is Mary Jo and maybe one other idea to interject here is that the Standards Committee, you know, doesn't – the Standards Consumer Technology Workgroup doesn't have to look at policy issues –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
Yes.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Of setting limits on data or not that that will come out of the Policy Consumer Empowerment Workgroup.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Thank you for that reminder.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Yes, so I think that it's good to – and certainly as we know they're pretty acutely aware of that, but if you're – I think you're monitoring that group's work as well, so just to be sure that you feel that it's being addressed.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Thank you Mary Jo. Other comments or questions, or discussion?

Fred Trotter – Founder and Healthcare Data Journalist – Not Only Dev
This is Fred Trotter, you know, this is another one of those areas where policy and technology kind of go hand in hand and are difficult to parse out and separate because I think I also have a concern about policy issues, you know, there is this patent troll going after PHR vendors now and I have been asked to sign NDAs in order to do open source work with device manufacturers all of which is to say there is kind of a movement inside Health IT to do things that amount to bad actors in the ecosystem that we're relying on to solve a lot of these problems.

So, there are a lot of these things that have been left to the marketplace and they're not working because of various, you know, problems. I've actually been thrilled to see Continua in their presentation that they've really kind of gone open source and HL7 has opened their standards and there has been a lot of movement in the right direction, but a lot of the foundations of what we're talking about here presume, for instance, that device manufacturers will kind of be good actors and give over their data to their patients in a way that they can give them into these kinds of pipes that we're talking about opening here.

That's a squarely policy technology issue and I don't know where to address it but I do see that it's not being addressed in these recommendations.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
You know, Fred that's a great point.

Fred Trotter – Founder and Healthcare Data Journalist – Not Only Dev
Probably because they can't be.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
It can't be, I mean, that's a great point whether – even if there were policy for us to address that the levers that we have are around Meaningful Use and assumes a user of HIT and our role is to reflect how standards can help empower consumers and enable the policies that have been generated out of the various committees including the Consumer Empowerment Team and the Meaningful Use Subgroup.

So, I think it is an open question worth discussing, it's probably not going to happen in this team, but it is a question and I also think it's what John talked about in the PHR specification it would be interesting to have you and he talk about harmonization of efforts to make sure that when there is an opportunity to address that we've got some good work already in place.

Fred Trotter – Founder and Healthcare Data Journalist – Not Only Dev
That sounds like a reasonable solution.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
This is Mary Jo again, at the risk of jumping in where perhaps I shouldn't the slide that you now have up, the bar that's –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes?

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Under device which says consumer directed, consumer products mobile which is not yellow because they're not ready for some of the reasons that Fred just mentioned I think it is in scope for this Workgroup to make a statement about the status of standards in that area and the problems that exist, and then do a hand off and call this both a policy issue and a technology issue, but I think you can comment on that block which is not yellow and make recommendations as to who would be the appropriate actors to follow-up on what might need to be done in that area to bring them along toward greater use of open standards or interoperability.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
That's a great idea, thank you, we'll do that, that's great and I think that could be applied to any of the areas we're not saying it's ready why is it not, you know, look at the consumer centric world and think about how we work, we work on our Apps or we work on our desktops, or we work in our iPads and our domain is much more aligned to our home and office use.

I mean, in my ideal world I'd have – I could go into Word and look at a template and click on it and I've got a consolidated CDA and it might be called Word for Health and a template or on my iPad I could do the same thing, it would be wonderful to see that kind of integration but we're certainly not there yet. So, I do think it's worth commenting perhaps on each of these areas that aren't in the yellow.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Hey, Leslie, this is John again, I think I did spot a gap in the list of information that we're collecting here and that would be the direct to consumer lab results. Some consumers –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Oh, gosh, yes.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Yeah, what they do is they go directly to the lab because they have like a lifelong disease or injury, or something like that and they don't need to go through the doctor every time and so they just go directly to the lab, they send their specimen in and they get the report back. Now from time to time once that data gets collected the doctor might need to have it imported into the EHR system but the PHR seems to be a good home for some of that data. So, the information would be direct to consumer lab results and orders.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
And then the functionality would be the bridge between the PHR and the EHR.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay that's great, thank you.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Hi, Leslie, this is AJ.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Hi AJ.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
I think this is very comprehensive, very good and I'm trying to understand where the transport standards fall under, because when I look at it I look at it in a simple way, you know, there is a content standard and most of the – and that's covered very extensively here, and the other major part is transport standards.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
That's great.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Whether it's Direct or Blue Button Plus API and I'm just trying to see in this table in this section the Meaningful Use 3 ready table does the message column actually cover that transport?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
If we could go to the next slide please? Oh, back one, I'm sorry then, oh, maybe it's the one that had – there you go. So, really I think we should be, again I'm talking about patient generated health data inbound so I didn't include the Blue Button today, but I think that's worth noting that there is a natural perhaps the use case of – that provide access to data of patients is something that helps to inform that inbound information. So, what would you suggest we would change here AJ?

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Well, what I would suggest is that we need to focus a little bit more on the transport, because the PGHD when we talk about data flowing from patients to providers particularly that transport, the current transport the Direct transport is actually, at least from the technical point-of-view, it's not the most optimal way to make that happen, because –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
What would you suggest for inbound data from a patient for transport?

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Yeah, I would suggest the BB Plus API standard.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
So, that is for pulling data out, it doesn't yet address inbound data.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Okay, so that's what I actually want to elaborate on.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
At the technical level there is at least conception that the API is actually only pulled, in fact the BB Plus group now is changing their nomenclature because the pull and push term was misused there. I think it was the pull. It gives people a sense that the Blue Button Plus API spec is only for pulling data from provider to patient and that in fact is wrong, because API by itself, as what we've used, at the International Industry, API itself is a two-way communication it essentially links the other – the application can send anything to API and get anything back to API as well. So, it's always a two-way data communication. It's not a message sending message type of concept.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
That's a one concept use in fact.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
Okay.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
So, I think we need – at the technical level we need to actually, you know, clarify a little bit that for PGHD what we really want in the transport is a capability that can easily send data back and forth two ways, right?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
So, I think that we also heard from Wes Rishel on that point that the API is the technical part of it, but also connected to that is the roles, responsibilities, the actual trust bundles and the policies that go along with that. So, that was one of the reasons why the Blue Button today is really still at an outbound and not in an inbound level because we lack the infrastructure of trust for the inbound data in that case. But, what I will do is change that column from messaging to messaging/transport and note that there are emerging opportunities in the Blue Button API. Okay?

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Okay.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
All right.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Yeah, certainly I would appreciate it if you could include the Blue Button Plus API there.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay. Other comments and questions?

Brian Carter – Executive Strategist – Cerner Corporation
This is Brian Carter a little further to the transport mechanisms.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

Brian Carter – Executive Strategist – Cerner Corporation
I think when you're thinking about what the right answer is here, when you're talking about APIs or OAuth or SAML you're really relying on the developer of the application sending that data to already predict and be aware of what systems they want to be able to transmit that data to, but then if you're thinking about something like Direct you're enabling the consumer more to decide where they think they may want to send their data. Direct being a much more federated idea where every developer doesn't have to be cognizant or developed for every possible end point in abstracting that problem away a little bit.

So, from my perspective I really do like the Direct concept because I don't have to predict where I'm going to need – where my users are going to want to send their data quite as accurately.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
That's a good point. I think we – when we think of Direct it's really messaging, it's really an e-mail. When you think of an API that's much more of an application to application program interface, well it is. So, they're different use cases.

One of the things that Dixie Baker talked to us about was that step needed where a patient presents to a provider and the patient knows who they are the patient issues a portal address or an account information and then the patient or consumer is able to register once they've gone on-line authenticated, register that account to an App of their choice, which is really the Blue Button Plus model and so that does reflect steps that aren't necessarily needed in a simple e-mail transport. So, I'll try to highlight those differences here.

Brian Carter – Executive Strategist – Cerner Corporation
I would just say too that the Direct model, it can work a little bit like an API, right? So, when I send you an e-mail if I have an attachment on that e-mail that I created in Word we're really using e-mail as an API between our two instances of Word.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right or a consolidated CDA for that matter.

Brian Carter – Executive Strategist – Cerner Corporation
Yeah, exactly.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
Yeah, let me just comment on that. So, and you are right that the Direct can be made to do the two-way communications just as API, it just uses – underneath it just uses different mechanisms, you essentially use an e-mail server and API uses a web server. So, ideally we would like to have, at least in my view, we would like to have both there for transport, because they all have – these two the Direct and API has their own limitations and also advantages.

And it would be really better ideally to actually recommend Blue Button Plus API as a new mechanism, it doesn't replace the Direct, it does not say that Direct in any way is not appropriate; it really provides a new mechanism.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
That will create another type of adoption and also quicker implementation.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yeah, it's an "and" not an "or" yeah.

AJ Chen, PhD – Chair, Data Committee – National Partnership for Action Region IX Health Equity Counsel
That's right, yes.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, any other comments or discussion? Have I named all the standards we heard about in a way that folks can get behind? Does this feel comfortable to people given our caution early on balance and really open this up? This is a strawman I'm just trying to recapture what I've heard from people providing testimony as well as the group.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Leslie, this is Susy Hull, I'm just a little bit late on the call but I've been here a while.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Oh, hi Susy.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Yeah, my only question, I apologize for making you repeat it, but have you narrowed the scope to inbound patient generated data from the patient into the EMR? Is that what I'm understanding versus –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes that is the current what we were tasked with from the patient team or the consumer team on the policy side is are we ready, are standards ready for patient generated health data? And where are there gaps and what is missing? And can we go to the yellow slides again? So, the attempt there is to say here are the things that we think are ready but there are still gaps and so we have on the slide previous the participants, identifying the patients, their roles, responsibilities, the care team members that's pretty solid and already been harmonized across many of the HL7 efforts.

And then going into the specific types of patient data that we've heard about we think that messaging is pretty solid and also with alternatives as AJ and Brian just pointed out, that the structured questionnaire under HL7 because it's taken the approach at that header level and the templates are already ready to go for primetime that there is an opportunity there. And there is also less resistance because this is in response to a provider initiated question.

And then also the unstructured data, there is some that's not ready for primetime but some hybrid approach of structured template with unstructured narratives there is an opportunity there and then there is also ready for primetime on the devices. So, that's really my strawman of what I think I've heard from everyone as to where we're ready for primetime.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
So, everything that's not in yellow is not yet ready for primetime?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Correct.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
And then will we be making some supplemental recommendations for those or are we going to stop at the –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
No and to Mary Jo's point it's very much worth a comment to say how are they not ready and where are the opportunities for them to evolve. So, if we have suggestions for the policy group to take something on or a combined Workgroup or recommendations for instance that the S&I Framework look at harmonization across – for versioning, reconciliation, curating and governance in general that's a body of work that has to go across anything from a care plan to patient generating home lab results and a patient having lab results come from a commercial laboratory.

So, that's a big body of work that we could make recommendations on. So, today's task is really what's ready for primetime and then we need to come back and comment on the areas that aren't. Does that make sense?

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Yes, yes, thank you for clarifying kind of the staging of this I appreciate your wisdom in framing the stages. One of things I'm seeing proliferate in the marketplace is a lot of, you know, the 30 day re-admission whether these are through mobile devices or other ways to mediate with the consumer there is a lot of questionnaires being passed back and forth so it may be a questionnaire that looks at medication adherence, it may be a questionnaire that looks at levels of pain or, you know, weights, daily weights whatever it might be in those tightly controlled 30 days. Where does that fit into this because some of those are coming –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
That would be –

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Some are coming to devices like they could be through mobile alerts but they also could be, you know, of the patient's choice, the patient could be using a web application or even telephone but it's a lot of patient generated response data by directed questionnaires.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
I don't think that – I think we've looked at this more of as a device agnostic approach and perhaps it's worth mentioning text specifically, I think that was addressed, Continua talked to us about that, but also I think this worth noting as a separate item that we are assuming somewhat of a technology agnostic approach and this is really about format versus prescribing that it's a web service or prescribing that it's a phone App or a desktop App, it's just all merging. There doesn't seem to be a way for us to even define a bright line between those things.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Okay.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
This is Mary Jo again and what I think that I've heard you touch on is really significant in that it would help you as you, you know, do what you said will probably be phase 2, you know, in other words the things that are currently non-yellow, but pointing to an enormous policy driver like the 30 day re-admission reduction is justification for you to select those non-yellow areas that most specifically would be supported or promoted, or touched by that requirement and to perhaps suggest, you know, focus first on those areas and exactly what is the status of standards that would support all that and then where there are deficiencies look first to recommendations about how to address that. And again, any other really major policy driver that is out there where you know the market is going to be responsive and could be going down either a lot of dead ends or at least a lot of unproductive alleys.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
I think to your end, to your comment Mary Jo, we heard about patients with congestive heart failure and the scales at home and how much that device data getting back to the EHR absolutely prevents re-admissions, absolutely helps to manage the care, I think one person that we heard from had gone from like four admits a year down to one because their weight was managed and their diuretics were managed well. So, that's a really good point sort of to frame this in the high value areas or opportunity areas for policy.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
It's sort of like an example use case that would get a lot of people's attention.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yeah, okay.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Hey, Leslie, John Ritter again.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes?

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
I'm looking on the screen here; I'm looking for traditional medicine and self-care categories like daily exercise.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
It that under self-outcomes or is that under holistic and integrative collaborative care?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise
It should have been in the structured stuff and so it's really the wellness and prevention you said, what else?

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Traditional medicine.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yeah, okay, I'll reflect that.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Okay, okay.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Other questions, comments? Does the group feel comfortable going forward with the recommendation that basically says, yes we can support patient generated health data with the standards understanding we have a bias for existing standards and we believe there is enough to choose from and we do not believe that standards are a barrier to the advancement of this policy, are we comfortable with that?

Brian Carter – Executive Strategist – Cerner Corporation
This is Brian I would say the only thing maybe we're not comfortable with is the array of options of standards to choose from not the dearth of options to choose from.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Do you have specific recommendations?

Brian Carter – Executive Strategist – Cerner Corporation
Well, I think especially in the transport mechanism space, you know, between Direct, OAuth, SAML, Blue Button Plus I don't know that I'm prepared to say I think we should do this one. I do feel that this group probably needs to have a little more conversation around what we as a group think the recommendation should be just so there is an area to focus on that everyone can rally behind.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, so in your recommendation it is especially around transport that we need to spend more time on?

Brian Carter – Executive Strategist – Cerner Corporation
I think it is mostly transport. I mean, when you look at your picture of those options, you know, when we get into the structured and unstructured you've got two things listed under messaging, we have five.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Can you turn that to the next slide please Caitlin or wherever the slide is that I have that has the –

Brian Carter – Executive Strategist – Cerner Corporation
It's slide 26.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Twenty-six, thank you. So, I was looking at the existing Meaningful 2 standard, Meaningful Use 2 standard and I think the one that's not in there or reflected under there is OAuth 2 but each of those others were mentioned I believe and so I may have that wrong. So, rather than saying there is a choice of things to deal with I was trying to state here are the existing standards that have already been named that can be applied to patient generated health data.

Now we could say that for instance Direct might be ready for primetime sooner, obviously OAuth 2 is not. So, I think there is an opportunity even –

Brian Carter – Executive Strategist – Cerner Corporation
Right.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Do a yellow boxing on these.

Brian Carter – Executive Strategist – Cerner Corporation
Right, yeah that would probably be my recommendation.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
So, for instance if we said Direct is named in Meaningful Use 2, we know that that's a ready for primetime based upon that. So, we could highlight that yellow and put the rest in with other work even the API is still right now in its infancy on outbound data and yet to come and address the inbound data which we hope it will do. The question is will it do so in time for Meaningful Use 3.

So, what I'd like to hear from the group if they need more time to deliberate, great, please get back to me, but if we have some discussion around what should be yellow boxed in this area for adoption, I'm hearing from Brian he feels comfortable with Direct, but perhaps not others. I hear from AJ that we need to add the Blue Button; I guess I would argue that that's not quite ready for inbound data, but it should be up there as a consideration. Are there other thoughts on the messaging of what should be yellow boxed?

I would argue too on the structured and unstructured data the consolidated CDA is ready for primetime but the FHIR is still emerging on the provider's side, we don't know enough about that yet. Would folks agree with that statement?

Brian Carter – Executive Strategist – Cerner Corporation
I'd agree with that we like the direction of FHIR but I'd agree that we're not ready to say its primetime.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, on the device data the consolidated CDA is being used today, Direct is being used as a transport, there are also FDA requirements for every device that's pretty much not up for grabs I guess. Do we feel comfortable with a Continua standard as a recommendation that would be yellow boxed? Does anyone feel uncomfortable with that? Okay. So, I will go forward with what I'm hearing and yellow box these.

On the vocabularies the reason that I've mentioned both SNOMED CT and LOINC, SNOMED CT is what's named in the problem list it's underneath the common Meaningful Use data set and so forth. And LOINC is an opportunity and likely for lab results but also there is underneath LOINC a lot of more emotive results like readiness ideas are within LOINC that could be used within a patient generated health data questionnaire. Do we feel comfortable with going forward with both the SNOMED CT and the LOINC? Does anyone feel uncomfortable?

Brian Carter – Executive Strategist – Cerner Corporation
This is Brian again; Cerner is very comfortable with SNOMED and LOINC.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

Brian Carter – Executive Strategist – Cerner Corporation
So, those feel fine to me.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
This is Susy I think that the questionnaires I was talking about many of those, the answers, those more emotive results can be coded with LOINC as well.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes, okay, so that's why it's meant to go across all of them, the gray set not lined up underneath just unstructured so I'll make that clearer. Okay.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Leslie, this is Mary Jo again, just from a process point-of-view I think one of your next to last slides had Dixie's, actually it was forward a little bit, you know, that well known matrix or grid –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Of maturity and adoptability, you know, when you go to the Standards Committee they would probably be looking for you to have, you know, position your recommendations along that grid.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
And clearly you've gone by definition to things that you're comfortable are fairly high along the continuum and may even be very, very high in the national standards space there. So, again that's just – you'll have that slide in your deck at some point anyway.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
We hope to – what I was hoping to do today is get the idea of what we're yellow boxing here and then I'll go back and make a strawman for our next meeting and have the group respond to that.

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Right, right.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
And then we'll be ready for, in terms of process, we'll be ready for the joint meeting in October, which is I think our timeline.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Hey, Leslie, this is John once again, I'm doing my best to try to think out of the box and recall many of the conversations we had on the HL7 personal health record workgroup side of things. One of the issues it came up with is a go between, between the patient and the healthcare professional that is the patient can generate some data and the professional can generate some data. There could be a go between that triages or helps navigate –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
Or serves as a paid professional concierge, an expert eye that can collect some of the data that's, you know, random and undisciplined but, you know, useful from the patient put it in a package, you know, that's filtered and tailored just for the doctor's peculiar needs and send that on so it becomes not patient generated data but patient triaged data by a paid professional.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
That's a really good point.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
So, our team right here is concentrating on the patient generated data and we're trying to elevate the level of trust and put some discipline with some standards. This triage person has not yet been invented here in the United States, but I think it's going to have to be invented over the next 5 or 10 years otherwise what we said earlier in our call there will be an overload of sometimes pretty useless data being blasted, you know, or pushed into EHRs that really don't make much sense and they would have to be filtered.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
So, we don't have that on our chart yet.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Can you go back a couple – can you go back to the slide that has, oh that one, go back to 25. So, this – I think what we need to do is beyond the versioning, reconciliation, harmonization, governance and curating there is this other opportunity and I'm not sure what that word might be, but we were trying to get at that in the long-term care or the longitudinal care team they were getting at that idea of curation or arbitrage or triage and none of us could come up with a word.

John Ritter, MS – Software Engineer - Co-Chair EHR Workgroup and Volunteer HL7
I like curating, I think you did a good job there, let's call it a curating expert.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, great.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
The other, this is Susy, I was thinking about the same thing on that slide as well as in slide 14, you know, one of the things we're trying to really get to is really much more active exchange and whether it's consumers mediating the exchange into these various things or to a health databank. I think, you know, the EHR is where we're looking at right now but the form of the EHR is going to change and the type of data is going to change. So, I'm wondering about the word exchange and if we actually have that in our diagram it seemed like –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
That's a good thing. Let's go to slide 14.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
It kind of came too short of where we see the future and, you know, focusing our recommendations now, but I think when we get into these things where we're curating data and data is getting, you know, repackaged in different ways for sense making for the consumer and the provider or their other support system. The notion of exchange might be helpful to add.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
In addition how those words fit on this diagram.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Sure and I've got a lot more to add to this slide based on the conversation today. So, I will definitely include that. All right, are there other comments or questions? You guys feel good about going forward with this? Okay, I hope that silence means approval.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Leslie?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yes?

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Where is the other Workgroup the Consumer Empowerment Policy Workgroup, where is their progress today in relation to these standards and is there anything from that Workgroup that we need to just be attuned to as these recommendations get formed?

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
They really asked us the question which is what can we support for standards? They asked us to specifically look at device data, at structured data, at unstructured data. In their group they heard a lot from providers that said that they don't want noise that structured data was very important to them. They wanted to make sure that the information came back in a way that was consumable and didn't put a new burden on their staff and so that really began the notion of the structured questionnaire versus that hybrid or that consumer generated content.

So, they really gave us those tasks. So, inbound patient generated health data, structured, unstructured, messaging and then what are opportunities for care planning. The group is talking a lot about care plans in the future and one of the things we heard from Russ Leftwich is actually that the development of the HL7 care plans might be further along than our policies are today and that's good news.

So, at a minimum when we start thinking about patient generated health data and the definitions the idea of the care team, who are the care team roster, who are the participants in care is a very foundational thing to do so getting that right now and then harmonizing that with future care planning efforts I think is very strongly desired from that group.

So, what I've tried to do is craft our discussions as we went through this using the guide post from that Consumer Empowerment Team. So, I've tried to constrain some of the discussion when we've wanted to go outside it given that task from that group.

So, it has brought up opportunities for us to discuss things that were more broader in the future as that team presents new ideas but for now we were given specific tasks and it may feel a little bit narrow and somewhat on purpose.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Thank you.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives
This is Russ, I think, you know, indirectly that the care team roster is important to patient generated health data as well because when the professional care team members get information pushed from a family caregiver they need to know who is that if not the patient and it often may not be the patient.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
So, Russ if we go to the slide that has the standards recommendations please then we should put ready for primetime in there specifically the care team roster because we've gotten that pretty well harmonized across everything.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives
Yeah, I think the version 1.0 of it.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Yeah.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives
Certainly some of the value sets for associations that I don't think exist we should not propose for Stage 3, but just, you know, a person ID and participation as the HL7 term for somebody that's involved with a process.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives
Those standards exist in our –

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Right, I'll make sure that gets added Russ to the slide. I think its slide 24 is that correct? Next one, next one, yeah, here, so Russ we'll put that – actually we need to add that to the standards.

Okay, any other gaps? Well, if there is no further discussion from the group and I'll ask first from staff if I've left anything out in our tasks that we were assigned, if we have any gaps we need to fill, is there?

W
Not that I'm aware of.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, Mary Jo?

Mary Jo Deering, PhD – Senior Policy Advisor, Office of Policy & Planning – Office of the National Coordinator
Good work team.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, super then I think with that we'll open for public comment.

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Operator can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute
If you are on the phone and would like to make a public comment please press *1 at this time. 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. We have a comment from Mark Savage; please proceed with your comment.

Mark Savage, JD – Director of Health Information & Technology Policy & Programs – National Partnership for Women & Families
Hello, this is Mark Savage with the National Partnership for Women and Families and I just want to say this is an exciting conversation to hear, I really appreciate the work, thank you.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Thanks, Mark. Any other?

Ashley Griffin – Management Assistant – Altarum Institute
We have no further comment.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Okay, then thank you all very much for your work on this and efforts and if you have other ideas that come to you later please get them to me and we will look forward to our next meeting when we'll talk about maturity of these standards. So, thank you very much with that we're adjourned.

Susan Hull, MSN, RN – Chief Executive Officer – WellSpring Consulting
Thank you.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Thanks, Leslie.

Leslie Kelly Hall – Senior Vice President, Policy – Healthwise
Bye guys.

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