

**HIT Standards Committee
Consumer Technology Workgroup
Transcript
February 14, 2014**

Presentation

Operator

All lines are bridged.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee 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 this meeting is being transcribed and recorded. I'll now take roll. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Russ Leftwich?

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

Here.

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

Hi Russ. AJ Chen? Anshuman Sharma? Arthur Henderson?

Arthur Henderson – President – Affinity Networks, Inc.

Here.

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

Good morning Arthur. Brian Ahier? Brian Carter?

Brian Carter – Executive Strategist – Cerner Corporation

Here.

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

Christine Bechtel? Liz Johnson? Fred Trotter? Holly Miller?

Holly Miller, MD – Chief Medical Officer – MedAllies

Here.

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

Hi Holly. John Derr?

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

Here.

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

Kim Nazi?

Kim Nazi, PhD, FACHE – Management Analyst - Veterans Health Administration

Here, thank you.

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

Hi Kim. Mohit Kaushal? Susan Hull?

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

Here.

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

Good morning Susan. Susan Woods? Ellen Makar from ONC?

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor – Department of Health & Human Services

I'm here.

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

Hey, Ellen. And are there any other ONC staff members on the line? Okay and with that I'll turn it back to you Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks, Michelle. Today we're going to go through the full recommendations and output from the Consumer Technology Workgroup, from our workgroup. This was used in conjunction with the Clinical Ops Group; I believe I have the right name Michelle, and also what we used with John Halamka in presenting to Meaningful Use.

Before I get the slides I do want to share a quick story I did just earlier. I was at a critical access hospital yesterday in the middle of Colorado speaking to their county commissioners and their hospital administration and chief medical staff officer and staff and we went through patient engagement and one of the members of the administration team said "oh, well, what we're going to do is a strategy using standards and we are going use Direct for messaging and we plan to really be expert at the Consolidated CDA." This is a 34-bed hospital in the middle of Colorado.

And one of the medical staff spoke up and he said, "I think this next evolution of Meaningful Use and standards will be HL8." So, I'm in the middle of Colorado, 400 miles from the nearest airport and people are talking about using standards-based approach for patient engagement. So our work is good and working.

So with that let's go onto the slide deck, next slide, please. So, we took – can you go back one please? From our group, I think it's the next one, the next slide, that one, thank you.

From our group's recommendations a smaller group then split out to use the expert panel members that had provided testimony to us to come up with some recommendations and overview and this group was pretty amazing and I'd like to call out in particular Russ and Lisa Nelson, and Chuck Parker, and David Kibbe who really did a great job of all this foundation. Next slide, please.

So, again you guys are very aware of our scope. Next. Let's – where we left off is focusing on standards for patient generated health data. Next please. Let's go next, I'm sorry. So, what we discussed was an emphasis on the interoperability between systems. We also know that tethered PHRs will continue to operate with proprietary approaches.

And so our real emphasis on how do we make sure there is interoperability between systems and to make sure that there was consistent EHR communication to expand to patient generated data. And what we heard often was “I don’t want a bunch of PHRs and portals to go. I want to send the same information the same way to all of them.” Next slide.

As you recall our recommendations across the continuum of patient generated health data from messaging to secure questionnaire, unstructured questionnaire device, plans of care and collaborative care planning and we went forward with recommendations on each of these. Next, next.

So, a little bit about the Consolidated CDA, we had some discussion about that it wasn’t really well understood and Lisa Nelson came up with the idea of garanimals and many of us are old enough to remember Sears and whatever you bought for your kid would match something else you bought and this whole garanimals approach is really where the Consolidated CDA is now, it’s a harmonized template and each template is a set of instructions about how to use the architecture, but each template can be combined to form different types of documents and because we took this approach that said we were constrained at a header level every template could benefit both the provider setting and the patient setting or a care team setting. Next slide.

So, the header approach all benefits apply to all authors. There is no separate but equal approach for patients and when it encourages innovation and collaborative records it also makes sure that the EHR is capable for any Consolidated CDA, it’s capable for all. Next slide.

So this is a little bit of the detail behind the document header and I’ll take some time here and ask Russ to also pipe in. Remember in our discussions we talked a lot about how do we know about provenance, how do we know about who’s the custodian of the record, who’s the participant of the record and all the performers, and this structured approach for patients in a Consolidated CDA means that we’re really taking a humanistic approach, an agnostic approach.

There are a lot of people in a team that could create a document that’s relevant to care, but making sure we have the opportunity to identify not only who they are the role they are to the patient and things like the legal custodian, the legal Power-of-Attorney, a parent role, a person who happens to be a doctor and a patient all of these can be accommodated within this approach.

And because we have this garanimals method it gives us an opportunity to always take a look at new templates and new designs and apply them to all care team members. Russ do you have any comments you’d like to make there?

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

Well, just that the authorship stays with that information as it goes to other systems so with respect to the concern that some have that, you know, I don’t want the information in my system that’s from a patient because, you know, well it’s labeled that it’s from a patient so and always remains that way, it should, you know –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Provenance stays there everywhere, all the time.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

And the other I guess, we’ll get to it later, but the ability for patients to be the authors did not exist until the current update of the Consolidated CDA standard.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you, next slide. Russ you want to talk about this?

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

Sure, so the care team roster is one of the proposals that needs to be incorporated. There is in the current 2014 certification criteria the idea of a care team being required but the use case for that is really transitions of care.

The requirement is to include the primary care provider of record the receiving provider, assuming it's a referral or a discharge, and other care team members, if known, it's only a text list, there are no specified attributes and there is no mention of the family or caregivers being part of that care team. So, it's a very limited representation of the care team that is not interoperable and would be difficult for a machine to utilize that information.

The proposal for the future is that the care team be health professionals, family and community caregivers as well, that they be represented as HL7 CDA entries with the existing HL7 standards that include the ability to identify health professionals by a unique identifier like the NPI number so that they can be easily identified across systems that it include their taxonomy, their role in this particular care team meaning are they a specialist who is the de facto primary care provider or a specialist who has been a one-time consultant and that it include physical contact information but also an electronic address like a Direct address so that the care team members can communicate with one another.

Likewise, for the family and community caregivers they should be identified by their familial relationship and by their legal relationship to the patient and also have electronic contact information like a Direct address so that the whole care team can exchange information.

It's really important I think too, going back to the last slide and the CDA documents that might be contributed by family members, it's needed to be able to identify who that individual submitting that document is with respect to this patient if they're an adult child, a daughter who's married, it may not be at all apparent by their name that they have a relationship to the patient so it's important to have that information incorporated in the CDA header as part of the care team.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

And for longitudinal care coordination across organizations to be able to transmit, if you will, that care team along with the rest of the clinical summary so that everybody on the care team knows who else is a part of it and how to get in touch with them.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Great, thank you, next slide. So, we focused in on the use cases that each of us talked about in our meetings. We described to share information with the patient, to share advance directives, to get device data from a patient and to use questionnaires. Next slide.

We reviewed the standards that were under each of these areas in detail and talked about how compatible this was with existing Meaningful Use recommendations. Next slide.

Here are some recommendations or actual examples of how the document structure would be used to provide a medication list. So, the point of these slides were to demonstrate that this is not unusual or unknown today it's currently used in things, this example I think is from NoMoreClipboards. Next slide, please.

Advance directives is something that also came up as a use case and consistent with other recommendations the ability to not only see a current version but link to an external source version was a component that was discussed in the Meaningful Use Work Team across other document considerations as well. Next slide.

We also reviewed the maturity of each of these standards. Next slide. And as you can see if something is mature in one area but new to the patient it's somewhere in between, but according to NwHIN standards it's still ability to be adopted nationally and to build on the current efforts. Next slide. Direct, the Consolidated CDA as well. Next please.

We also talked about the Continua Standards Organization or being much more like an IHE than it is an HL7, it's really a community group that's come together. We talked about the maturity and we reviewed all of the considerations under Continua. And this provides a set of guidelines and provides a set of security and also operates in seven different international test houses today. Next slide.

So, Continua allows for certification and we had talked about the need to have not only at a device level but also potentially a hub or aggregate level and HealthVault was one example that was used. Next slide.

So the use cases that we considered under devices were the exchange of – directly from a patient or the exchange through data through an e-mail, so you can see the consistency of these standards throughout our recommendations.

This is using a Consolidated CDA or can use a Consolidated CDA and its structure. It can also use Direct and the point of these slides was really to demonstrate the continuity of the recommendations across current standards efforts. Next slide, please.

Again, the underlying components of each of these standards that are already completed. So, this is something that when we talked many people brought up things like “I want to know blood pressure monitoring or weighing scale, glucose” those were the items that were brought up most often in our discussions. Next slide, please.

Okay, next slide. We also talked about patient reported outcomes in our meeting and it was important to be able to receive patient reported measures and this is not only because we see more data coming from the patient but we also see much more interest in policy leadership like the PCORI investment that really emphasizes the need to advance standards and patient reported outcome measures. Next slide.

We also discussed the use cases from getting information within a device for the patient reported outcome measures, again, still using the Consolidated CDA, can use a RESTful approach, can use advance onto some further discussion that we’ve had earlier about OAuth 2 and other types of approaches. Next slide, please.

It was very encouraging when we discussed the structured and semi-structured questionnaires in detail. We saw how much of that work in the Consolidated CDA can be used to support not only templates that are multiple choice or numeric, or free text, or perhaps a slider or discrete slider it also allows for templates for preconditions and to ask questions if the answer previously was yes and also for copyright information we can honor any particular patient reported outcome measure copyright within this structure, which was very important to many of the vendors, they’re coming forward with things like a PAM score for instance could potentially meet that. Next slide, please.

So, recommendations are that when a patient generates a response we use the Consolidated CDA and the patient generated data header templates and when the clinician uses it it’s the clinician header. So, the templates for capturing patient response also within the patient reported outcome measure. So, we really got a three-for-one with all these recommendations. Next slide.

We go into further descriptions in detail about the kinds of questionnaires that can be used so we’ll just go through these quickly. Next. What I’d like to do is – I think we’ll go directly over to the next deck on slide number four if that’s possible. While we’re switching slides are there any questions?

I think we’ve heard all of this before, this was just an opportunity to get into much more detail. There was considerable discussion in this team and also with others, the other teams that we met with. John Halamka provided some great oversight and discussion. We took that information and then John and I presented an abbreviated version of these slides with recommendations and so I’ll go through those pretty quickly and then we’ll go into Q&A. Next slide, please.

So, the overarching recommendations were that there is a concern regarding certification only items as systems must be engineered to incorporate standards and processes which may not yet be mature. That is an overarching concern and one of the reasons this group went forward with recommendations that were consistent in Meaningful Use. And that the standards application should be constrained to where they are needed and useful. So, those were the guidelines that we were working within. Next slide.

So, where there is a need for patient data sharing the Consolidated CDA is agreed to be suitable, it’s also recommended as a container for certain types of templates that are well understood like problems, medications and allergies.

So, the Clinical Operations Group has agreed with our findings with these caveats and also with these overarching themes. So, the Consolidated CDA over existing Direct and exchange and other modes of transport are reasonable ways to get data in and out of EHRs and PHRs, and patient facing systems.

The Consolidated CDA should not be required as an architecture for organizations to have to use, but the outcome goal is for the entire team to be able to contribute to an integral medical record. If unable to integrate systems must have the functionality to receive a Consolidated CDA containing specific templates like goals of a patient participating in problems, medications and allergies, and we need to allow for innovation and flexibility in this space to not unduly constrain options for individuals to connect with their care teams in ways they prefer in the future.

So, we're suggesting using the consolidated template payloads are sufficiently mature but not over specify how they are to be moved about. So, this was really great, the group went through a lot of deliberation and felt that this was directionally appropriate. Next slide.

Did we skip one? I'm sorry. No, I'm sorry, thank you go ahead. So, we want to allow for innovation and the marketplace is clearly still evolving. The group agreed that the Continua standards are directionally appropriate but need to align with current FDA guidance and other regulatory or sub-regulatory policy without constraining the marketplace.

So, there is a lot going on in this area especially as we consider that devices might be part of mobile. So, there is a lot of consideration and what we're hoping that this kind of alignment happens, which of course the Office of the National Coordinator is tasked to do is to create alignment moving forward.

We also understand that there is immaturity in the market and we need to allow for flexible adoption of device data and other remote data sources. Next.

So, we also talked about the existing recommendations. So, the existing, phase 3 recommendations as stand on the policy side, this is a menu item that providers and hospitals receive provider requested electronically submitted patient generated health information through semi-structured or structured questionnaires and that the outcome of this is that we will enable patients to access and transmit their information, provide ability to contribute information to the record including patient reported outcomes and provide tools to help patients actively participate in their care.

You might recall in other areas of Meaningful Use we've always talked about certain percentages or numbers of use, we're looking at low, medium and high thresholds, and in this case this would be a low threshold for use. The argument being is once you've done it once you're going to do it many, many, many times. Next slide.

That's the – I think we're – yeah, okay, great. So, we – in a nutshell we have agreement for directionally appropriate for non-tethered PHRs for our recommendations and we had good discussion, good deliberation and we feel very, very confident in this approach. Russ do you have anything to add and I know – I think Sue Woods is on the phone and see if there are other comments the group would like to make.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

We did identify one standard that was incorporated into the recommendations and that is the HL7 in December published an implementation guide for electronic questionnaire and response which is a framework for using CDA to create electronic questionnaires and the corresponding response to those questionnaires leveraging the existing CDA section templates and entry templates to construct questions which should be very important in enabling the patient reported outcomes as well as other questionnaires to return the response in a form that systems can consume and will enable things like having a software service, a web service that might be the mechanism of administering a questionnaire via a web form, if you will, and then returning the results to the system as a CDA document that could be consumed.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So things are marching along and we feel very confident, especially now with the Meaningful Use 3 dates shifted we've got a lot of time for the industry to move forward in this direction and I think each of us felt pretty confident that the recommendations from this team were listened to with extreme due diligence and consideration and have come to a point where we all feel very positive about the outcome. And I'd ask anyone else – I'd like to open up for discussion or comments, or feedback?

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

Leslie, this is John Derr that was very good. I was wondering when we talked, you know, one of my windmills is including quality of life in the advance directive.

Are you going to talk more specifically about some of these things or like there is advance directives on one of your slides in the first deck and that, are we going into more depth on things like that and also on the professionals I just wanted, since I also represent pharmacy, to make sure that one of the care team people is a pharmacist.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, I'll answer the first question and leave the second one to Russ, but we aren't going to go in more detail in this team but I would encourage you to look at the use cases under the HL7 Consolidated CDA template where we have discussed advance directives as one of the templates going forward and quality of life – I'm not sure that particular item might be there John but I think there are goals. So, that does bring up another area of work that this year we'll be looking at which is taxonomy and vocabulary for consumers which would include things like goals or quality of life issues.

So, there is some work yet to be done in that area, but check out the implementation guide for the beginning structure and I would also encourage you to – if you have recommendations to that group for specificity on advance directives to get involved.

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

Okay, thank you.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Russ do you want to comment?

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

Yeah, sure, absolutely I think the intent is to enable the care team roster to include the entire spectrum of professionals and family, and community members that are part of the patient's care and to have a way to externally, outside the system, identify them like the NPI number for the professionals and Direct addresses for everybody on the care team or some other electronic address, but Direct would seem to meet the requirements and to enable the communication that way with pharmacists and every other professional in the community who is part of the patient's care, but to make that part of the patient's information as, you know, fundamental as the medication list and the problem list I think is very important and to expect that to be part of the patient's clinical summary that's passed amongst the care team if you will.

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

I just –

Holly Miller, MD – Chief Medical Officer – MedAllies

Hi, this is –

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

John Derr, again –

Holly Miller, MD – Chief Medical Officer – MedAllies

I'm sorry.

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

Just let me – excuse me I'll just follow-up. I just wanted – sometimes I have to explain that there is this other pharmacist that's out there now called a senior pharmacist, because as you know I work a lot with the American Society of Consultant Pharmacists and the Senior Certified Geriatric Pharmacists are sort of in private practice so as I see ACOs coming about, medical homes and the beacon communities I see – I'm starting to see these type of pharmacists playing a role or coordinating medication management and not just a list and I just want to make sure you all knew about that. Thanks.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks, John. Was that Holly?

Holly Miller, MD – Chief Medical Officer – MedAllies

Yes, thank you, I just wanted to speak in support of what Russ was saying I think that it's a critical point and it's a point very well taken. In addition that list, the maintenance of that list rests under the control of the patient to add and remove in a go forward fashion and that everyone on that list would have a Direct address to be included.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, great, do we have other comments?

Holly Miller, MD – Chief Medical Officer – MedAllies

So –

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

Good morning everyone this is Suzy Hull, just an interesting thought as you're talking about the role of the pharmacists and the geriatric pharmacist. I think the retail pharmacist often has a lot of contact with the patient but is often not connected to the care team. I imagine that there is accommodation for that but any additional conversation about the retail pharmacist in addition to the pharmacist that might be in private practice or a pharmacist that might be part of a formal care delivery system.

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

And this is John Derr and you're absolutely right and the problem with my profession or the one that I went to school on is that there are so many different pharmacists out there that sometimes it gets very difficult and as I see as get more and more into analytics that the – and as you all know the other aspects of medication management is dietary and therapy which usually is in the care planning stage and those three elements really interact with each other because if you change medications you usually have to change diet and you usually have to change the therapy or the therapy or drug might cause a side-effect that might be classified as musculoskeletal and it's really a side-effect, so as we progress on longitudinal care and get in more analytics then those elements will have to be taken into consideration.

And I did, as Leslie knows, I did recommend to Doug Fridsma when I was on another group and we were talking about the advance directive and I did mention that, you know, as you just said Holly about the pharmacist really sees the patient a lot more than many of the other professionals that might – and has a great sophisticated IT system it might be the repository of the advance directive because I forget which group I was on, but somebody gave an example of somebody going to the hospital and the lady was asked where is your advance directive and she said it's in her safety deposit box in the bank which is not accessible. So, that's just something else to throw out.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah with regard to the advance directives this approach within the Consolidated CDA that allows to go to link to an external source for a more current version has been used in not only describing advance directives but also used in recommendations under imaging. So, I think this idea of linking to something current will become very prevalent within the recommendations.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

Yeah, I think that's a very important concept that a document that's created and is – has a date that it was created and has not changed thereafter is not the ideal format for advance directives and that a link within such a document to a registry, if you will, of advance directives is a lot more – is a much better concept to allow advance directives to be exchanged, if you will, where the link is always pointing to a current dynamic document if you will.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes. So, I think that where we landed is a good really solid recommendation and was encouraged by the idea of directionally appropriate and to accommodate both the needs of new consumer standards and also to accommodate really responses that we will see that the industry will have to implementations in Meaningful Use 2. I wonder if I've left anything out there with regard to next steps or process Michelle?

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

Well, the first step is that the recommendations will be reviewed with the Standards Committee during next Tuesday's meeting and then, you know, after Tuesday's meeting there will be a discussion, a high level discussion of the Standards Committee work plan and I think after we flush that out a little bit more we can decide on how we work on some of these other activities that were discussed on today's call.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

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

Just the group is aware and you'll hear it on Tuesday, originally we were planning to update some of the Workgroups and have a detailed work plan to review with the Standards Committee at the meeting next week but because of, you know, we have a new National Coordinator and, you know, things are evolving we are not yet ready to share that and we want to make sure that we do it right and do it in alignment with, you know, where ONC is headed and where the Standards Committee thinks that things should be headed.

So, it will be a much more high level conversation than we had initially planned. So, I guess it's kind of a wait and see but it doesn't mean that you can't start to think about what you'd want to work on and still, you know, start to line things up.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks Michelle, I think where we had discussed is in the future things like a consumer vocabulary needed to be worked on how would that – how did we envision a consumer vocabulary being used in conjunction with Jamie Ferguson's team and then also we had looked at future things on care planning and hoped to have some consideration to build upon the care team roster recommendations that we had gone forward with now.

So, I think those were the main areas that I can think of off the top of my head. So, it will be very interesting to hear the results of the work plan and exciting to get the new coordinator's interests and considerations in our work going forward.

So, this team has created a great amount of work and consideration for these recommendations and I really appreciate all of you sticking with this and continuing to provide feedback throughout this almost, oh, guess over a year's worth of work. I'm confident in where we're headed and excited.

And as you know we are, as a result of this new work plan, there will be consideration on teams going forward and the construction of the teams, the work plan, the teams are assigned and the membership.

So, as you remember in December, I believe, we asked if there was interest from all of us to participate going forward and that also ONC was going to go through a process to match the memberships the work team and the work effort.

So, I would expect that we would have some consideration for this new team formation over the next 30 to 60 days is that reasonable Michelle?

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

Yes and I think, you know, you said it Leslie depending upon the next steps for this group, obviously we'll want to make sure that we have the right people identified and just make sure that we have the right group of people going forward.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Great, so thank you. Any other comments or considerations?

Holly Miller, MD – Chief Medical Officer – MedAllies

Hi, I just wanted to thank the committee for their outstanding work.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you, Holly, I appreciate all of the work that this team has done but not only that the work that each of us then has taken on to promote and support patient engagement concepts in HIT throughout the industry. I know Holly has been active, Russ has been active in the longitudinal care team record, in Direct, in many areas of HL7 so not only has each of use brought work to this team but we've acted as ambassadors promoting standards and promoting patient engagement and I know I can count on each one of you to continue that being an evangelist for the patient as part of the care team and the standards that can support that. So, thank you very, very much.

Brian Ahier – President – Advanced HIE Resources

So, this is Brian Ahier.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Hi Brian.

Brian Ahier – President – Advanced HIE Resources

I just want to remind us to consider that when we talk about patients and their ability to be an active participant in the care team that we usually include patients and their caregivers and authorize patients representative's ability to access information and contribute information and participate in the process is important and sometimes has technical architecture implications for the ability for them to be able to act as proxies on behalf of the patients. Particularly –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you for that reminder Brian because that was an important consideration as we went through the care team roster to make sure that family members, others that their relationship as well as their authority within that relationship was articulated within the care team roster so I appreciate that reminder.

Brian Ahier – President – Advanced HIE Resources

Okay, great.

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

Leslie this is Suzy Hull I was kind of thinking in preparation for our meeting today and the agenda moving forward for the year, where do you think the intersection of mobile health, telemedicine might be?

As you mentioned earlier this is a – there is a lot of activity in the marketplace it's immature it's moving forward but I see a need there for some real emphasis given the proliferation in the marketplace and particularly the impact for the patient may have more – may come into more contact through telemedicine, mobile health opportunities than the traditional EMR.

I know it was originally further down on our roadmap, but how do you see that evolving in our Workgroup this year or even in other Workgroups?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That's a great question and it's been brought up in a variety of areas because it is a nexus point of telemedicine, mobile health, HIT devices these are all sort of mingling and each one of them represents potentially different areas of regulatory oversight but a commonality of use in that I could be a patient on an iPhone with a device associated with it and doing telemedicine, and doing secure messaging, and accessing my PHR.

So, it does bring us into this new world and to my knowledge we do not have anything emphasizing that nexus point as far as a Workgroup and that's an important consideration that we'll take forward as a request or question to the Standards Committee.

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

Right and I think Russ mentioned the publication from HL7 in December on the implementation guide for publishing questionnaires, I think this is a big issue.

I was talking with a mobile health startup earlier this week and, you know, they're really not in the loop and are starting to develop their – what they're calling their own evidence-based questionnaires, but thinking about, again so many of these vendors are considering developing their content for these questionnaires and may not really be connected to the standards world in a way that will allow us to have something that's a bit more interoperable.

And I haven't looked at that implementation guide but I'm wondering if it's all transportable to the mobile health or telemedicine world.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

We did take a neutral or an agnostic approach to naming device type and the standards themselves can carry forward into web, mobile or other.

So, we've not taken an approach that would say – to be too prescriptive of that but rather to be very neutral. But it's a great question and I think we should bring that up in the Standards Committee.

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

Thank you.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

And the Continua Alliance has been involved in the development of that questionnaire and response implementation guide as well and maybe one of our meetings in the coming months could be a presentation from them about how that and device data may come together –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That's a good idea.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

For stability in the future.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Any other considerations or questions this group would like to see going forward for discussion at the Standards Committee or discussion in further work plans?

Holly Miller, MD – Chief Medical Officer – MedAllies

Certainly – hi, this is Holly, certainly considerations around identity proofing, privacy and security. I think that we need to – and I saw those in the slides that were given out but I think that a plan around that would be great and I would be very happy to participate in that myself.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That's great and for ONC staff this is the discussion that has started – has been ongoing in the privacy and security policy area but I believe in the privacy and security standards area we've not discussed this yet and this is really recommendations for level of assurance around patient generated health data or other patient participation within the HIT ecosystem and that is something that is being discussed in the industry.

I know in DirectTrust they're discussing this but it would be worth having some further guidance. So, if that's something we could tee up as well to standards that would be helpful.

Holly Miller, MD – Chief Medical Officer – MedAllies

Yeah as well as considerations around the DirectTrust bundle as we think about where the messages are going and what systems are involved and ensuring that direct trust is always there.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right, thank you Holly. Other considerations? So, we have some questions to put forward as well as our status update in the meeting this week. That's great, well if there is nothing else does staff have anything to add?

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

I don't think so but thank you Leslie for all your hard work on this we greatly appreciate it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Oh, thanks Michelle, back at you. All right, well I think with that I think we can wrap up.

Public Comment

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

Okay, 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 no public comment at this time.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

All right, super. Well thank you everyone for your hard work and Happy Valentine's Day.

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

Happy Valentine's Day Leslie. Thank you everyone.

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

See you soon.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks guys, bye-bye.

Russell Leftwich, MD – Chief Medical Informatics Officer – Tennessee Office of eHealth Initiatives

Thanks.

Brian Ahier – President – Advanced HIE Resources

Bye-bye.