



**HIT Standards Committee
Content Standards Workgroup
Final Transcript
November 24, 2014**

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – 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's Content Standards Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I will now take roll. Andy Wiesenthal?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Here.

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

Hi, Andy. Rich Elmore?

Richard Elmore – President, Strategic Initiatives – Allscripts

Good morning.

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

Hi, Rich. Calvin Beebe?

Calvin Beebe – Technical Specialist - Mayo Clinic

Here.

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

Hi, Calvin. Charles Jaffe? Clem McDonald?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Here.

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

Hi, Clem. David Dinhofer?

David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services

Here.

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

Hi, David. Dianne Reeves? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Here.

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

Hi, Floyd. Grahame Grieve? John Klimek?

John Klimek, RPh – Senior Vice President, Standards and Information Technology – National Council for Prescription Drug Programs

Good morning.

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

Good morning, John. Joyce Sensmeier?

Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN - Vice President, Informatics - Healthcare Information Management Systems Society

Good morning.

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

Hi, Joyce. Kelly Adrich?

Kelly Aldrich, DNP, RN-BC, CCRN-A – Informatics Nurse Specialist - HCA Healthcare

Here.

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

Hi, Kelly. Kevin Kirr? Kim Nolen?

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

Hi Michelle, I'm here.

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

Hi, Kim. Kin Wah Fung?

Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Here.

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

Hi, Kin. Marjorie Rallins? Susan Hull?

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

Good morning, I'm here.

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

Hi, Susan. And from ONC do we have Matt Rahn?

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

Yeah, I'm here, thanks.

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

Hi, Matt. And Mazen Yacoub?

Mazen Yacoub, MBA – Healthcare Management Consultant

Here also.

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

Yeah, he's here.

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

Hi, Mazen.

Mazen Yacoub, MBA – Healthcare Management Consultant

Hi.

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

And with that, I will turn it over to Rich and Andy.

Richard Elmore – President, Strategic Initiatives – Allscripts

Thanks, this is Rich Elmore. First of all, we can at some separate point all find out from Andy what an amazing trip he just finished to Bhutan, which just sounds incredible. So, welcome back. He's had a few

more hours of being awake than we have, on his return, so he'll catch up quickly here, I'm sure. But in any event, we wanted to do just a quick agenda review. We wanted to cover with you some thoughts on how we answer questions that ONC may have and how we work collaboratively with the other standards workgroups to accomplish that. Michelle will take us through that. We'll do a work plan review of what our next few steps are going to look like and assuming Charles is able to join us, we're going to get an update from the EHRA from Charles Parisot, their findings related to Consolidated CDA version migration and cut-over. And then we'll finish with some public comment. So, welcome everybody to our second meeting. Andy?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, thank you Rich. I won't belabor the point, I just would point out to everybody that I hardly recommend long vacations in places where there is no email and no wireless connectivity. I'll turn it back to Rich.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Is there any such place?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, Bhutan; high on mountaintops in Buddhist Monasteries, although the monks, I will say, have cell phones.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Ah, I knew it.

Richard Elmore – President, Strategic Initiatives – Allscripts

Plausible deniability will only get you so far, I guess.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Right, right.

Richard Elmore – President, Strategic Initiatives – Allscripts

Well, let's turn it back to Michelle and Michelle, maybe you can walk us through the workgroup efficiency.

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

Sure. Next slide, umm, and next slide. So during this past Health IT Standards Committee meeting last week, Steve presented an idea to the Standards Committee to make sure that we're making the best use of everyone's time across the workgroups and across ONC and just making sure that we're being as efficient as possible.

So what we discovered as we started to establish and think about the work plans for the new workgroups, which you all know we just kicked off and at this point, I think all of the Standards

Committee workgroups have now kicked off. But we've realized that there is a great deal of overlap across some of the workgroups and that a lot of the work needs to be interconnected. We're finding that it might be a little bit difficult to be passing things back and forth between workgroups on the standards side so what we've decided to do is to think about how we can be a bit more efficient and in order to do that, we have talked about forming task forces that will be formed and similar, as all of you are aware, over the summer we formed the JASON Task Force, which was a very successful group. It was a short-term task force that was made up of Policy and Standards Committee members. They worked all through the summer very hard actually, came up with recommendations and the task force is now disbanded.

And so our goal will be, if there are specific questions or items that we need answered and they touch multiple workgroups that we'll identify specific members from the individual workgroups that would be appropriate, so subject matter experts that would be appropriate across the different workgroups and form a task force to help answer that question, rather than going back and forth between workgroups, which we just think a lot of information can get lost in translation sometimes when you do that.

So, an example here would be for something we're talking about later today, but as we talk about C-CDA a bit more, this work could potentially touch this workgroup, the Semantic Standards Workgroup and the Implementation, Certification and Testing Workgroup. So as we continue to think about questions and work that could be associated with this, we would for...poll specific members from these three groups and form a task force to answer a specific question. It would be a short-lived group that would eventually go away.

So our plan is that there are still a number of major milestones that we'll need the workgroups to respond to, so coming up we are planning for in January, for the Interoperability Roadmap to be released and a number of different workgroups will be responding to that. And then at some point, workgroups will be...you'll also get a presentation actually in December on the Federal Health IT Strategic Plan. And then at some point, groups will be responding to the Certification NPRM. We are planning for the winter for that to happen; we'll see when it actually falls. But this workgroup will certainly be responding to the Interoperability Roadmap and the Certification Rule.

So our conversation today will actually be helping to prepare for response to the Interoperability Roadmap and what we are assuming will be in the Certification NPRM. And then following that time, there might be a specific charge or question that ONC has that we will need to work with a few subject matter experts from this group and others to continue questions or a work effort. So, hopefully I helped to explain that, I'm sure Steve did a much better job at the Standards Committee, but hopefully at a high level that makes sense to all of you. Are there any questions? Okay...

Richard Elmore – President, Strategic Initiatives – Allscripts

Michelle, I think...this is Rich, I think that was a good summary. I mean I think a good example for this group just to focus the mind is, to the extent that there are questions around NCPDP standards. Some of us have expertise in that, some of us do not, so getting a subset of this group focused on it along with the other standards workgroups working collectively we think can result in a higher quality, more focused result than trying to do it from the various vantage points of the full workgroup.

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

So not hearing any questions, we'll certainly keep you updated as we work through the process and you'll obviously know if there are specific questions that certain members of this group will be answering as we move along. I think that we are working on getting Charles on the line, so hopefully we'll be all set to transition over to him soon. Next slide.

So just kind of going back to how that affects the work plan. So we are going to have a couple of discussions related to C-CDA, Clem doesn't know yet, but he did some homework after the last meeting that we are hoping he can present to the workgroup at our next meeting on December 12. And then we are thinking at the January meeting we'll do some work around responding to the Interoperability Roadmap; and then...which will be presented at the January Standards Committee meeting. And then, depending upon, as I mentioned, when the NPRM comes out, we'll comment on that as well. Next slide.

Okay, so I am going to turn it over to perhaps Matt to help provide a little bit of context into what Charles will be presenting, how this came up and some thoughts around today's call objectives.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Could you be sure to clarify what I'm supposed to do on December 12, this is Clem.

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

Oh Clem, I'll follow up with you, but, we want you to share some of the homework that you did around the C-CDA recommendations that came out from the Implementation Workgroup. Matt?

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

Hey, so this is...go ahead Michelle, were you going to say something?

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

No, I was just looking for you; there you are.

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

So, this is Matt Rahn. Thanks everyone for joining. Do you know if we have the speaker, by chance, Michelle?

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

We're still waiting, I'll let you know.

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

So, there is going to be an update to the C-CDA from our 1.1 to 2.0 and so Steve thought it would be a good idea to kind of pull the EHRA vendors and kind of get a sense to them like some specific questions

around the transition from 1.1 to 2.0 as well as other things. What needs improvement for greater interoperability with the C-CDA standard? And where the problems and what should we be trying to fix?

We're going to have EHRA come on and discuss pretty much what they had gone over at the HIT Standards Committee is the responses to that poll of questions that we had for them. So today we'll be discussing those and then next time, we'll be, as Michelle eluded to, we'll be discussing the Implementation Workgroup's recommendations to constraining the C-CDA and Clem had some comments and updates for that. So, as she said, he'll be discussing those with us next time. But today we just kind of wanted the EHRA to present to us so that we can get an idea of what we should be doing going forward and hopefully you guys will have stuff to add or discuss based on their feedback. Other than that, that's really all I have, but if the speaker is not here, then maybe we discuss Clem's stuff; but I don't know if he's on yet.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I'm on, I just don't know if...I wasn't cued about this and I'm not sure if I am the right expert even.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well I think, Matt and Michelle, this is Andy. That would be a little unfair to Clem.

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

For sure, more than a little.

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

No. Yeah, I think we're working on getting Charles.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, I can tap dance for a couple of minutes. People will have at least gotten the slides and I don't know if anybody who was present at the original presentation has any comments to make on the presentation or how it was received by the committee. So I'll ask that question, Floyd, were you there by any chance and any others from the Standards Committee? Maybe we lost Floyd. Maybe we lost everybody and we're just talking to ourselves.

M

There are a few of us out here.

M

Yeah...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, hearing no one, that's the end of tap dance routine number 1. What I would suggest is that the committee membe...because I don't think we're going to get our speaker, and it seems foolish for us to...

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

He's on the public line, so it's not that...I can see that he's there, he just needs to call into the IP number that was sent to him, if he can hear.

Richard Elmore – President, Strategic Initiatives – Allscripts

Well, post a text message to the whole public and have him call you on your cell phone.

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

We pretty much have.

Richard Elmore – President, Strategic Initiatives – Allscripts

He must be listening to us if he's listening on the public line or not.

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

So, somebody has their computer speakers on.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That's a real echo, isn't it?

Richard Elmore – President, Strategic Initiatives – Allscripts

That's a hell of an echo.

Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology

Sounds pretty good, Michelle.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

Charles is here, I really apologize, I tried to log on as a member to give the presentation and I was rejected. So...

Richard Elmore – President, Strategic Initiatives – Allscripts

Well here you are thank you.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

Thank you very much, sorry for that.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So, we're ready any time...this is Andy Wiesenthal, I'm speaking as the Co-Chair, we're ready any time you are for you to proceed through your material. And I would ask folks to allow him to do that, unless you have a specific question for clarification let's hold questions to the end.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

So, let's dive into the material, so, next slide. Thank you very much for having me and EHRA. This is a piece of work that we've done as a result of a number of discussions involving some folks from ONC, Wes Rishel and a number of other people that were concerned, and I would say rightfully concerned, as to what was going to happen we move from one edition of the C-CDA to the next on or one version to the next version of the C-CDA. And when that concern was raised, there was a questionnaire developed and what EHRA offered was to run this questionnaire through their members.

And that questionnaire was also along with a sample that was a C-CDA that was created as a mixed C-CDA to being both 1.1 and 2.0 with some dual template ID, and we will dive into some of those details, with the purpose of asking the vendors, what would happen if you get that into your system? Does it choke? Does it die? What's happening? And these are the results that I would like to present now.

We had 26 of our members...we had a little less than 40 members, so 70% of our membership responded, so we have pretty coverage of a variety of vendors and also a variety of implementations. So, this was quite instructive. As I said, we have seen how different EHR developers are taking different strategies; some are very conservative and concerned that they may get information not quite right and create errors for the clinician or in their software so they are somewhat protective. Others are more lenient and try to be more flexible and between the two, there are a whole bunch of shades of gray, and you will see those displayed as we go through the outcome of this study.

The important point is that what we found was nothing new, those were things that are happening with all of the standards that have been in use, the same issue would happen with V2 message, the same issue would happen with FHIR. So let's make sure we don't think that that situation is specific to the C-CDA standard, it's specific to the fact that implementations approaches information they receive in different ways. Next slide.

The first question was what would happen if you receive a C-CDA and you do not recognize the template ID, that ID which is all the way in the header of the document? We had almost 80% of the EHRs that would store this and 2/3 that would be able to display. So 1/3 said, hmm, suspicious document, it's noncompliant because there should be template ID, therefore I will be conservative and I don't want to make any error, I would report something which is either an error or an alert, and you see this in the second question, raising an alert, was done by 23% of the implementations. Some rejected the content and some actually chose not even to make the document viewable.

So a variety of reaction and it is quite clear that if we get a new version with a new template ID, not recognizing this template ID is going to create problems. So this is in our face, we cannot ignore this and we need to manage it and make sure we have good reality not only in the spec, but also in the test tool and as well on the...in a good education on the side of the implementers. Next slide.

The next question came around the fact that you have, in the C-CDA Release 2, the structure of the template ID that has changed. It is now a two-part attribute expressed in a simple way, the basic ID and an extension to this ID, so in a sense a sub-version or a minor version element in this attribute. And the question there was, would your system simply ignore this extension that is not used in C-CDA Release 1.1 or would your system simply say, oh, the whole thing is different, it is not a 1.1 and would not even process the body of the template.

So that's an area where there was a problem and there were a large number of systems that would be confused by that. So, that's a lesson structuring the template ID is a good thing, but implementations need to be programmed ahead of time to deal with that and not be confused by that new C-CDA 2.0 structure. Next.

What would happen if you had two template IDs in the C-CDA that is received by the system, a C-CDA Release 1.1 template ID and the C-CDA 2.0 including, of course, the extension as we discussed before? So we had 80% of the systems that would be able to accept this and...process the contents, and we'll see some further discussion on this coming to the other slide.

And out of this it became quite clear that a dual personality C-CDA that is 1.1 compatible and 2.0 compatible was a promising direction, but there are a number of things that have been changed when the content of this section has essentially the same semantics. So this created some confusion and this led a large share of our membership to make the comment to say, hey, before we finalize a C-CDA 2.0 ballot and the comment resolution which is still under way, there are a few things that...changes that have been made that maybe we should not have made because they are simply creating backward compatibility problems without, I would say, good or obvious reason. So, a little bit of a specification attention is needed here, and you will see that this comment comes back in a few places. Next slide.

The next comment was, what would you do if you receive a C-CDA 2.0 document that it not at all identified as a C-CDA 1.1, no template ID for C-CDA 1.1 included? And again, 80% of the EHRs would accept it and display it; however, we only had 60% of the 26 EHRs that they were able to process it; 40% that responded said, oops, no, I would not try to process it without that template ID. Same comment, let's make sure that in order to move towards a dual personality, we keep things consistent when they mean the same thing between the two releases, the 1.1 and the 2.0. Next slide.

A question now in terms of product evolution, and there are a few of those now to conclude the survey. We started with systems that currently support C-CDA 1.1, which is deployed and to which the vendors as an upgrade to support C-CDA 2.0. Would your system retain the capability for 1.1? Would you drop it and support only 2.0? Would you be still able to reconcile med allergy problems between the two versions? And you see those questions, including what would you do with the support of the older versions, C32 and CCR?

So we had a clear statement that says, 100% of the EHR vendors would support Release 2, would continue to support C-CDA 1.1 and would be able to navigate between the two, process and display, both versions, absolutely no problem. There was, however, a rather strong majority that says, hey, keeping capability to receive, process multiple versions, and this would line up 4 versions, is a little bit too much. Somehow we need to phase out the previous version, keep a display, still want display capability so we don't penalize the clinician but we don't try to keep the processing and do the extensive testing and capability to import the discrete data. So a suggestion here was to have some kind of a sliding window across a couple of version or two or three versions, but not all versions since the beginning of time. Next slide.

Let's talk now to vendors that would be implementing C-CDA 2.0 on a new product, which is not shipping and providing support of Release 1.1. How much of an effort would it be to add the support of 1.1 to the support of 2.0? Most of our members, probably given a, I would say, an evaluation answer because I would say most if not all support 1.1 today. But the implementers were pretty clear and said,

just a little bit more work to support two versions, but this is not a major effort and this is worth providing the flexibility. Slide 8.

So, let's come back to solutions now; two solutions were proposed. The first one is to be sending two versions of each document; so, if you have a new source producing a C-CDA 2.0, it would produce the existing content in 2.0 as an instance of a document, as well as in a Release 1.1 distinct instance of a document and actually send both versions, the two documents to the receiver and let the receiver choose whatever it can do with either one of those two versions.

We had a rather negative reaction to that, many concerns in terms of testing, of consistency of information and not actually being a real good solution that can take us into the future and would even confuse the clinician at point and wondering why he has two versions and which one should actually be considered if made visible. So that's something that didn't receive good support.

The next slide is another alternative that was considered, which is...sorry, I spoke to it before which is to create dual personality documents where the sections that are consistent are identical, both template ID are in the document and only the new information which is supported by Release 2 is added and may be displayed only or, in the worst case, ignored for processing, if it is received by a 1.1 type system.

So, the conclusion here is, we said there is work to do. We would like to have a careful review of the Release 2 draft as it is not quite frozen yet and make sure that all sections that are common in content are identical and backwards compatible and are not going to create hard...unnecessary difficulty for the systems that are programmed to receive 1.1.

The second thing is that if they are new, and there are a few new sections with new information, those should be added and we should accept that some older implementations that are supporting only 1.1 are not able to process, possibly to display, but not even to display that additional information. That's part of expanding the data set and that's something which we believe is acceptable, that should be clearly identified.

And finally, make sure we have a strategy, and we see the strategy emerging here, but a well-documented strategy that says template IDs are going to evolve in the following way, and you should be able to cope with a new template ID or an existing template ID with a different extension and this means this and these are the expectations that the system should support. And we think that this is important, allowing us to move forward in a known way without having to rework the already shipped and installed systems that are in clinical use.

Around this, adding a number of tests that test the ability to be forward compatible, in a sense, for the existing implementation would be a very, very important thing and this is something we recommend be included. To deal with all of those three issues, there is work on the testing side, but there is definitely work with HL7 and EHR implementers in making sure that C-CDA is conservatively evolving and not changing for the sake of changing. So we want to minimize version cut-over challenges; that is the suggestion.

This finishes my presentation and I would be very happy to take any questions, comments and suggestions.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well thank, you...this is Andy; appreciate very much the effort that this required. I will lead with a question that I had and I hope you can come to some kind of answer without compromising the integrity of your promises to the participating vendors. So without de-anonymizing the answers, can you give us a feel for what proportion of market penetration was represented by the vendors who did participate?

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

I would say a very large market penetration.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

Definitely I would say the more active members are traditionally in EHRA the vendors with the larger install base and number of customers. So, I cannot give you a number, but I would say this is definitely not a risk of a bias here of a big...I would say a lot of vendors with a small share. We had a few of those, it was actually quite...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

(Indiscernible)

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

...and their responses were not significantly different, everybody was at different places in that range of flexibility versus...business.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Great. Thank you, I appreciate that. So, I'll turn it over and open it up to the rest of the committee. Any questions like that of clarification of the basis of the study or around the recommendations for strategy and approach?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

This is Clem. I like generally the idea of backward compatibility, but there's some really bad problems in Version 1 related to drug prescribing, when I looked at it closely in that there's...it's not clear when it's a dispensed, when it's the order, when it's...that's one set of problems. And it's also not clear what you really put into the text sig...proposed a tightening of that to make it clearer, it wasn't the one I preferred but what would happen in that circumstance? Would we still have the mess of the first version where you really don't know where the sig is to the instructions for the prescribing instructions?

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

Clem, this is an area where you are touching on the three categories of changes with Release 2. We have new information that is introduced, completely new, sometimes it's a new section or it's a significant extension to an existing entry. In that case, we want to make sure that this is supported and if there was already an entry, the entry is processable, I would say, by 1.1. The second category is there are changes that are there simply because the writers of the information guide said, you know, it would look better, it would be better if; and those are the ones that maybe we should not consider doing those unless we have a clear reason.

And the first category is those where yes, the information is here, but the information was encoded, represented, organized in such a way that led to incompatibility at the semantic level; this needs to be clarified, this is likely to create a backward compatibility problem. We need to understand the backward compatibility problem. So that's...to me, this is not an issue and I don't...didn't hear anybody in EHRA that was not willing or interested to improve things, but we want to make sure we improve things and we understand the impact. And that third category may actually be treated like the second one. Yes, if you are a 1.1 version, you may not be able to do very much processing on that, you may be able to display it and that's about it. Yup.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I'm 100% behind the tweaks that tend to happen for no really good purpose that creates problems, so that backwards compatibility is always a good thing. I still don't know, is if the net would be that people would stay with Version 1 because they didn't have to change?

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

I don't think so. You've seen...you've heard the comment that said, there is a desire so that we don't keep too many previous versions, you understand, previous older version. Now we have four versions we need to deal with and there is, I would say, the reason for this is that when there is improvement that actually creates much better clinical certainty on the data, we want to make sure that those older versions become phased out. And in particular, the import and the reconciliation done on that information. We think over time it should no longer be supported and both clinicians and vendors should be pushed, in a sense, to support the newer version.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Okay. One other comment, I think your comment that the problem is the same with C-CDA and FHIR and V2 is, it's not quite right because none of those is as hard to read or follow for at least two versions of the C-CDA or ballots on it, you couldn't even get to the templates, they were off in somebody's special place. And I couldn't get to them the last time, if you just look on the web, you couldn't find them. So, there are extra problems with the difficulty in digesting it, I think, compared to the others. But just to put that on record.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

You are correct, I would say you were correct, the problems that we are seeing now that all of those I would say use type issues, like any standard when it is young and gets the test of fire, I mean, the real

world. Then there are things that need fixing, correcting that was unclear and that need to be improved. And honestly I have seen that with every standard in healthcare or even in IT. So, we should not be naïve, we should be hopeful that we learn, that we can do a bit better, but getting things right in terms of specification without the implementers working on it and deploying and seeing what the real world does with it is, unfortunately, a test that is the litmus test.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I just think that this contrast getting it right is always hard; being able to read it and understand it is the extra barrier that C-CDA put on us. I just...an awful lot to read and then you can't get, and we really couldn't get to...you couldn't look up the templates, so most of it was done by reference, a lot of it was done by reference and wasn't part of the package that you reviewed. That hasn't happened elsewhere in...well, V3 I guess does that, too. But that hasn't...that's not in FHIR and it's not happening...it didn't happen in V2.

M

Clem, we should talk about your problems in getting access to the materials that were balloted because they were available to everybody else.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well if...well I think...well, the linkage to the...what I was told, the only place that you could get it, at least a version ago, was from one site which was not open to the public. I know where it is now, but I didn't then and it wasn't in the ballot to say where to get it.

Calvin Beebe – Technical Specialist – Mayo Clinic

All right, yes. To ballot on the standard, you did have to be an SDO member to do that.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That...no, I'm one of them, I'm an SDO member. It wasn't HL7, it was on, and I can't remember, it's on the group that's building most of the CDAs, they had the templates.

Calvin Beebe – Technical Specialist – Mayo Clinic

All right, well we'll follow up and try to figure out why that was difficult. This is Calvin, by the way.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Thanks, Calvin. Any other questions? Clem, thank you and Cal for that discussion. So we'll make a note of it, that there's...there are always issues and these standards do have to get to a certain point of perfection and then get field tested. Other questions from members of the workgroup?

All right, well I think people need some opportunity to contemplate these findings and, because everybody has just heard them for the first time today. And I would suggest that we can have an email trail of conversation if we need to, and certainly discuss them at the next open meeting of the committee. So unless there's something else...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, let me get back...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

...yeah, go ahead Clem.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...I support these recommendations and would just caution about where there may be some lost information if they make it too backwards compatible.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah. And I think there's always that risk and the software vendors are...perhaps not in this field, but in others are quite used to that and at some point they declare defeat and we're not going to continue to make "X" standard backwards compatible past several different levels of versions. So, version skew is another way of putting it and they want to have some recommendation about how much we would require a vendor to do if we wanted to do it that way. All right, other questions or comments before we move on? Rich?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

On this subject or new subjects?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Oh well, we're not on to new subjects, I mean, within this presentation or something else entirely, Clem?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

It's something else.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, let's wait for that, we haven't gotten to new business yet.

Calvin Beebe – Technical Specialist – Mayo Clinic

Calvin had an additional comment that is related. I'm aware at the HL7 group that the publication request just got approved through the final group at HL7 so the Consolidated CDA 2.0 will actually be published in a final document from them here fairly quickly. So the balloting process is completed on this.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Does that inhibit this proposal?

Calvin Beebe – Technical Specialist – Mayo Clinic

Some of the recommendations that it still has months of time to go in and change it are...were true 6 months ago but are not true now.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Uh oh.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, so what would HL7 do with this if not ignore it?

Calvin Beebe – Technical Specialist – Mayo Clinic

Well, the challenge is, the governance rules we have don't enable us to take a ballot that's been finalized and published and...without republishing it to make a change, unless it's an actual error or errata. There is a mechanism for that, but it would require some pretty special new governance rules to be able to crack it open and make changes of the sort that are being asked for.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Could you do another ballot?

Calvin Beebe – Technical Specialist – Mayo Clinic

Oh yes, that you can always do.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, it sounds to me like that might be the course of action; no one wants HL7 to change its governance rules mid-stream, at least not right now.

Calvin Beebe – Technical Specialist – Mayo Clinic

Sure.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

But ignoring this would probably be...

Calvin Beebe – Technical Specialist – Mayo Clinic

No, I don't think we'd want to ignore it, I think there is lots of good items in here that need to be...again, and this is Calvin. There are a lot of good items that need to be focused on, at least clearly delineating why things are different is a minimum requirement that we need to provide feedback to the implementers on. But the idea that we could actually change that...the standard, it would take another standard or another revision of the standard to probably make the kind of changes that were being advocated if they were to be embodied in the standard.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Calvin, do you...be resisted?

Calvin Beebe – Technical Specialist – Mayo Clinic

No, I think there's a general acceptance that there's feedback that we need to accommodate and the question is really, what's the most expedient way to do it? I think the forwards and backwards issues hadn't been as much a focus as some of the earlier feedback, which was tightening up constraints, which adds to the difference between the two specs. And so, it becomes an interesting challenge, everybody wants it to do conflicting things at the same time; they want it backwards compatible and they want it to be specified tighter.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, that sounds...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Right.

Calvin Beebe – Technical Specialist – Mayo Clinic

And I'm not...and they're both very prudent and very desirable, it's just a question, how do you get the balance between those two?

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Maybe over time.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, is there someone who will do the work of doing a comparison, I mean available?

Calvin Beebe – Technical Specialist – Mayo Clinic

Well, I'd be possibly one of the people that could look at it with an eye toward the forward and backwards compatibility. I think the other question is what was documented in the standard right now? There should have been some sections in there documenting the forwards and backwards compatibility, so it would be interesting to go back and review those and see if there...

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

Yeah and...Charles here; I would say, if HL7, ONC engage such an effort, definitely EHRA would be willing to provide some resources out of our members who did this work to help do that as quickly as possible and if there is a corrective action, we'll have to take it. Hopefully there is none, but let's make sure we are conscious of what we are doing and why we are doing it and sometimes that is the best protection for the future.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, would it be possible to encourage that effort in parallel to figuring out how to...I mean, if it's not very heavy, it might be easier to find a way, if we knew exactly what was involved.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

I was told there was a meeting between HL7 and ONC on a number of CDA related issues earlier this month or it was...I heard November. I don't know if that meeting took place or not, if anything was decided there.

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

This is Michelle, the meeting did take place, but I think there's some additional follow up that needs to happen from that meeting.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

So this could be fed into those...this follow up?

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

Yes.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

Thank you very much and if there is any further question or analysis or input on this discussion, it definitely raised a lot of interest in EHRA to deal with this up front and to be able to test it and have a world view strategy going forward. Thank you.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I think we should thank you for helping to get some real data on this.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, no, it's excellent work and our thanks to the entire EHR Vendors Association for doing it; please convey those.

Charles R. Parisot – Manager, Architecture and Standards – GE Healthcare; Chairman, Standards and Interoperability Workgroup – Electronic Health Record Association

I will thank you.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Thank you. Okay Michelle and Matt, back to you. Do we have new business?

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

We don't. That was all we had planned for today's meeting. We wanted to make sure that this group had that background of context and I think during the next meeting, hopefully we'll be able to thread the needle with follow up activities with ONC and HL7. And also we will bring some additional information and follow up coming out of the Implementation Workgroup's recommendations. We'll probably ask Clem to present, and again, I'll follow up with you, Clem, just to provide some additional context so that this group will be ready to inform the Interoperability Roadmap and the Certification Rule, once it's published.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, could I just get something on the docket sometime in the future, maybe way in the future, but...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

It's Clem, so please go ahead, I'm just identifying you for yourself, Clem.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...so, we've got some good beginnings on getting labs sent from the producers to the users, but unless I, I mean I kept up, very little on getting actual reports, just the reports, EKG reports, spirometries, you could pick a list of 10 tasks that are used very widely and are multi-structured, and radiology reports are not, that are not set up to go from the requestors to the senders across institutions. And it seems like it's almost a sure bet, but we sort of just kept back from that problem and keep working on other problems. I think it would make clinicians happy if they could actually buy an EMR and load stuff in it without hand working everything.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Okay.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

It would be...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

So...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...enabling V2 to do a good job right now, because that's what we're doing with lab.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, we're going to discuss the roadmap and it seems to me that part of that discussion should be to include...to making it a little bit more...a little bit broader statement, include other categories of information that we would like to see included as part of the Interoperability Roadmap. So, larger textual reports, some of which have some structure to them, some really don't...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

...would be a category, so I think that's the one you're describing.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I'd even like...it's the folks, I mean, three...the cost for radiology reports are three times the cost for lab results. They're one of the really valuable things in clinical care, because you're looking right in the center of the body and seeing what's going on and we still haven't even mentioned them, you know, after...it seems like it's...they're probably the most valuable. EKGs ain't bad, they cost a billion a year, they're all fully structured and there's a nice interface comes out of the commonest producer of it, which I think is GE, which does about 70% of the business, and we just keep going on to these bigger harder things, it seems like, instead of tackling what's sort of halfway there.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

In the hospital they send them out all the time, they work fine within the hospital; we just haven't worked with breaking outside.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, well don't get me started on why radiologists should be allowed to continue to dictate sort of random textual reports without putting some structure in them, because that's a sensitive topic for clinical discussion, not this committee.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, I'm on your side on that, but man, I just feel...I would rather see the report than not, it ain't terrible and it's such a valuable piece of information.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

No, no, no, I'm not...don't get me wrong, but some...we could provide a little bit of a forcing function to make them behave better.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Right, if the clinician gets \$70/visit and has to code everything, they could at least code their impression.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah. Anyway, so I have no problem with including that in the roadmap discussion, because it's an important item; when are we going to get to the things we haven't gotten to that are big clinical...a big clinical payoff?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...the things we tend to do is be grandiose and they're really hard to do grandiose things and I'd like to take a couple of small ones we could bite off and actually get done in a realistic timeframe.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

All right, well, if you've got a list or if others on the committee have a list of those things, please submit them to our staff and we can make sure we incorporate them in our discussion.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Okay.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Any other new business or items to talk about today?

Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Healthcare Information Management Systems Society

This is Joyce Sensmeier. This relates back to our previous conversation; I'm sorry, I didn't get it in during that time. But, it may be a question for Calvin, so if we do another ballot for CDA 2.0 or whatever version it would be, what would be the quickest timeframe that that could occur in?

Calvin Beebe – Technical Specialist – Mayo Clinic

That's a great question. It really kind of depends on the nature of how the ballot process is supported. If it's completely driven just from volunteers, which has not been the norm at HL7 over the last couple of years with the ONC push for implementation guides. It could take well over a year and a half or two years. I know even with the funding of consultancies that do the work to do the lifting on the ballot process, it's at least a year, if not more. I mean, it is a fairly arduous process to...even for a draft standard for trial use, which is supposed to be our easy way to do it, to go through over 1000 comments that these ballots tend to generate. And I know the last one generated over 1000 comments that had to be resolved to take it forward.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Wow.

Calvin Beebe – Technical Specialist – Mayo Clinic

There's so much interest and focus, it makes it even a bigger task to get it done, which is good, but it's work.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well it sounds like the review should be done, and let's hope there's hardly any...some way to make it...

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah.

Calvin Beebe – Technical Specialist – Mayo Clinic

Just as a...this is Calvin again, just as an example, I took through HL7 as an informative document the companion guide that was completely developed by S&I and took it through a ballot with negatives and it...I did it on a completely volunteer basis, to try to help out, it took over a year to run it. Because you have a 30-day wait, you have a 30-day ballot, you have to close, then you have to start dealing with the negatives and then you have to get the publication cleaned up and then you have to publish it. And it...you can't hire people to do this work faster, but from a volunteer basis, it's...it just takes time to get that kind of work through the organization.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Yeah, and when you couple that...this is Andy, with the lag time that's of necessity built in to the EHR vendor development cycle, it could be several years before something sees the light of day.

Calvin Beebe – Technical Specialist – Mayo Clinic

Granted.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Well, we're going to have to figure that one out, but I don't think we can do it this morning.

Calvin Beebe – Technical Specialist – Mayo Clinic

Yeah.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

We can at least point it out. All right, Joyce, thank you for that question. Other questions or comments from the committee? Grand. So I think Michelle, we have to open the public lines for any comments or questions from the public.

Public Comment

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

We do. Operator, can you please open the lines?

Bess Hoskins – Specialist – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue.

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

We have no public comment at this time. So thank you everyone for joining, you get a half hour back in your day. Happy Thanksgiving to you all and thank you so much.

Andrew M. Wiesenthal, MD, SM – Director, Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)

Thank you.

Richard Elmore – President, Strategic Initiatives – Allscripts

Thank you, Michelle.