



**HIT Policy Committee
Interoperability & Health Information Exchange Workgroup
Governance Subgroup
Transcript
August 26, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Interoperability and Health Information Exchange Workgroup and this is a meeting of the Governance Subgroup. As a reminder, this meeting is being transcribed and recorded, so please state your name before speaking. Also as a reminder, this is a public call and there will be time for public comment at the end of the call. I'll now take roll. Carol Robinson?

Carol Robinson – Principal – Robinson & Associates Consulting

Good morning, Michelle, I'm here.

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

Good morning, Carol. Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Good morning, Michelle.

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

Hi, Chris. Anil Jain? Anjum Khurshid? Anne Castro?

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

I'm here.

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

Hi, Anne. Barclay Butler?

Barclay P. Butler, PhD – Defense Health Agency

Present.

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

Hi, Barclay. Beth Morrow? David Sharp? Deanna Wise?

Deanna Wise, PMP – Executive Vice President and Chief Information Officer – Dignity Health

Good morning.

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

Hi, Deanna. Elaine Hunolt? Jitin Asnaani?

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Hi, Michelle, I'm here.

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

Good morning. John Blair?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Here.

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

Hi, John. John Lumpkin? Mariann Yeager? Melissa Goldstein?

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

I'm here.

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

Hi, Melissa. Tim Pletcher? Tony Goldman, I'm sorry, Gilman? And from ONC do we have Kate Black?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Good morning, Michelle.

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

Hi, Kate. Kory Mertz?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Here.

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

And Jodi Daniel?

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology

I'm here.

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

Hi, Jodi. Are there any other ONC staff members on the line? Okay, with that, I'll turn it back to you Chris and Carol.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you, Michelle. Good morning, everybody, on behalf of my Co-Chair, Carol Robinson, I welcome you to this call for the Governance Sub-Group of the HLT...Health IT Policy Committee. I'm going to keep it short; the goal for me here is just to review the agenda with you. We will first review the results of the listening sessions. So those of you that had the opportunity to attend, these sessions, in my opinion, were extremely interesting, helpful and...but it was a challenge to summarize all the information that we received in these sessions.

And I think...I thank the ONC staff for doing a fabulous job in bringing some of that together. So, and with that, we will...after we will review the listening sessions, we will discuss the recommendations for our framework for governance, and that will take about an hour. And then we will have about 10 minutes for public comment. So, with that said, I think it's time for us to really get started on the actual task and go and talk about the listening sessions and what we have learned. So, can we pull up the slides? Yeah, there we go. And I think Kate; you will walk us through those?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Hi Chris, sure, I can walk through the listening session summary. Kory, if you want to jump in at any point, please feel more than free. We also have a moment to stop and take a break at the end of the listening session summaries to hear everyone else's kind of comments, feedback and observations as well. So, you can either interrupt me as I go, or at the end of it, either way is more than fine.

So we heard about a variety of governance efforts underway at the state and national level. Some were operated by states, but most were run by private entities, usually not for profit, and these efforts have varying policy frameworks, technical standards and focuses. Most of the governance approaches were voluntary; however, there were a few states that had a regulatory approach in place. Entities were generally focused on governing specific subsets of the exchange ecosystem, rather than trying to tackle it all, and they were generally tied to conformance and adhered to a set of standards and policies that accessed a certain set of services. The accreditation and certification were usually subcomponents of the governance entities and generally not the main focus. Next slide.

Stakeholders often voiced the need for ONC to move in the governance space, but some had varying perspectives on what role that should be. Some viewed the potential regulation as a helpful thing ONC could do, others felt like it should continue its leadership role through collaboration and partnership. A number of technology issues were still kind of slowing and inhibiting exchange and many people commented on the variability in the C-CDA conformances, implementation of Direct in EHRs, proprietary rather than a standards-based code used for transport and document display.

And people also noted that the misaligned incentives were a problem to exchange. In areas where incentives were aligned, we saw a lot of exchange, including in ACOs and things like that. Vendors and providers also noted that varying perspective of where business interests are and what costs what in the market is slowing exchange. Finally, we learned that exchanging data requires coordination and trust across a variety of players in the healthcare ecosystem since the ecosystem is at an early stage of implementing many exchange use cases, such as ToC, and is still working through some maturity issues. Next slide.

Can we...ahead? Thank you. Also, we saw that the cost of exchange was high and we're creating a lot of barriers to exchange. Some participants...or providers, I'm sorry, felt like they could not participate because of the high interface cost and high cost for different accreditation and certification programs. The differing technical standards across states and state systems creates significant cost for organizations that are operating in multiple states and the different accreditation and certification programs being used within regions is also creating an untenable situation for organizations who are operating in multiple states.

Varying requirements and interpretations of rules related to sharing of data, including sensitive data in terms of behavioral health, HIV and substance abuse treatment are also slowing exchange. And we also heard that re-engineering workflows that can use an HIT system and HIE to their highest level of effectiveness is difficult and providers often don't have the time or expertise to do that. Next slide.

Finally, we heard from other industries and got some good feedback from banking, the FCC, telecommunications and Internet groups and speakers stressed the variety of governance approaches. And most were kind of tailored and developed to specific needs and dynamics of the markets they served. They did say that they were mostly developed organically and were voluntary governance initiatives, especially in the internet and banking industries, where things really kind of erupted outside of the government. While the original impetus for governance development was often to address specific problems, the mechanisms created are still active and manage a variety of problems and interactions. Go ahead, please.

So we also heard a variety of recommendations, other than just basic observations. Panelists told us at the state, national and local level that we needed to develop a national address book to enable ToC and other use cases, improve patient matching. Narrow our goals to enable a deeper focus on developing the standards and policy solutions required to enable interoperability and at the national level, set common definitions, components and minimum standards for strong governance structures. This included different perspectives and roles including the provider, consumer and intermediary.

They also recommended that we need a core...a common core set of HIE services and standards that support healthcare reform. Standards for interoperability across healthcare settings and a minimum kind of recommended focus on accreditation and certification so that we could enable exchange between service providers across state borders. Next slide, please.

They also recommended that we needed a framework and mechanism for interoperability across entities providing HIE, so that providers and payers seeking to participate in multiple exchanges. Some of the issues that they recommended we focus on there were consent management, granular consent, tracking consent and auditing, clinical data query, data aggregation models, terminology mapping, message conversion and other more of the substantive focus issues happening between exchange, where policies often differ. They also recommended that we promote the emergence of improved tools for enabling exchange among unaffiliated entities by incentivizing desired outcomes for prioritized use cases, rather than specifying specific requirements related to how things are exchanged. Monitoring should be done through actors that are appropriately implementing interoperability standards. We should develop computable interoperability taxonomies and develop a voluntary model for data use agreements that all stakeholders can adopt. Next slide, please.

I thought that that would be it and thankfully, it is. I will stop my rambling now and open up the floor. Chris and Carol, if you have any additional feedback, or any of the other members of the subgroup, we're happy to hear it and take note of it now.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you, Kate. This is Chris and I appreciate you walking us through there. I think one of the things that became very apparent to me from the listening session, to look at it from a more...higher level is that we heard about a great variety of models for exchange. We heard about a variety of needs and perceived requirements in order to make these different models work. It is very interesting to me that certain functionalities that you require to do exchange in one model might be something that you also use in other models.

But, that there is a great number of flowers, if you want to say that there are a thousand different flowers of health information exchange blooming right now and all of them have certain specific features and certain specific needs and targets where they want to go. So, that became very, very apparent and it also made it then very clear that those fine points that you summarized here were not necessarily applicable to all different models of health information exchange, but represented a broad collection of needs and desires of the varying players in the current field. So, that became incredibly obvious, and I think really helped us in shaping our proposal for a governance strategy framework in the last couple of days. So, I found these sessions very, very helpful and thank you for doing such a fabulous job of summarizing it.

Carol Robinson – Principal – Robinson & Associates Consulting

Kate, I just want to concur that I think that you have done a really terrific job in pulling together so many disparate thoughts and the feedback from our panelists of the two listening sessions and I just thank you for that and for walking us through it. I would like to pause and get feedback from the entire workgroup now so; I just hope people will feel ready and willing to jump in with their thoughts on these summaries.

Deanna Wise, PMP – Executive Vice President and Chief Information Officer – Dignity Health

This is Deanna Wise. I would just concur that amazing job of the summary. I thought maybe the summary might take the whole time of the call to actually provide, but you guys did a really good job, so thank you.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Well thank you guys...this is Kate, for all of your feedback although I would be remiss if I didn't acknowledge that Kory put most of that together. So the kudos definitely go to him on this one.

Barclay P. Butler, PhD – Defense Health Agency

Hi, this is Barclay. I'll triple that, Kate, Kory, thanks so much for that. I will tell you though; my concern is the tremendous scope of this interoperability that we're looking at here that we see in the summary. I think a huge, I guess task for us is to figure out, and I think that perhaps may be our next steps is how do we pull out those most important things, address those most important things so that we can begin a path of accomplishing this interoperability. My fear is that there are so many topics and so many things to address that just in that load it may have a tendency to freeze us. We have got to avoid that, we have got to pick our key priorities and begin to provide a governance structure that will then lead to our overall goal of governing interoperability.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

That...

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

This is Jitin...oh, I'm sorry.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

That was a wonderful comment. I think looking at this initially, I thought oh my god, we're going to be paralyzed and...but your point is extremely well taken. There is a great need for prioritization, but also a need to take a step back and say, hey, what things do we need for what models of exchange. And I think that's going to be a critical piece of taking a deep breath and then reorganizing ourselves on those things that truly matter.

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology

This is Jodi Daniel, if I can jump in. I actually thought that was a really poignant comment as well and I...there are so many issues and we struggle with this as well at ONC. There are so many issues when we talk about governance that...and information exchange that come up. And I think one of the things that helps in thinking about it is thinking about what are the mechanisms that we can put in place to address those issues because we're not going to...new issues will come up down the road as well.

The goal of this group isn't to necessarily solve all of our problems, but help us think about a structure, a governance mechanism, a way that we can address those issues, and maybe help us identify where there may be some priorities for us to focus on. And I think that that might help to kind of get out of trying to address every single problem that's been addressed, because we know that there are many challenges. But helping us think about what we can do to start tackling those problems and coming up with a structured or a thoughtful mechanism for doing that on an ongoing basis.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, this is John Blair, I want to also thank, as the others did, the summary, I thought it was very good. I was in on the first listening session and then had to read the work on the second, I couldn't listen in, I was in flight. But I thought that was very good. I...just another comment that I think is similar to one we just heard before. I struggle with combining the query or the pull with the push side of this. Although there's clearly an overlap in terms of the...there are transactions in both scenarios on the security side, there are some...there is real overlap. But on the privacy side, particularly when you get into consent and patient matching and some other things, they are really completely two different animals. And I struggle with whether you pull these together under one exercise or whether you sub-segment those.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

Hi, this is Anne. I would like to say that this is an elephant that can only be eaten one bite at a time and that if we're, as Jodi suggested and I think it's an excellent suggestion, let's look at how you solve the problems, but let's look at the problem as the whole forest, not just the trees. If we just look at every tree in this forest, it is going to be a daunting task and we'll never make any progress.

My recommendation would be to crystalize the business needs that have to be satisfied first and insert clinical for business in this case. What clinical needs are the highest priorities that have to be addressed, give a time limit to a group of people who have to make a recommendation on the priority order, don't be talking for a year, two, three, or four, because we'll talk about this until I'm long gone. And then turn that over to a group that then dissects that into what's necessary to get a national solution. And then publish that and make that happen to the degree we can. We spend way too much time talking about everything and not getting to even making progress on...20% with depth would be better than 100% with no depth.

And a governance organization or group of people who will do that and not be caught in that quagmire is what is necessary, with complete transparency so that everybody gets a certain amount of time to vote. It's almost like an NPRM, just give them 30 days, comment on it, make a decision, move on, put a time limit on it, move it forward. We're not going to get anywhere if we don't do something to that degree. Thanks.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Hi, this is Jitin; I'll weigh in as well. I think it's complementary to, I feel, the previous comments we just heard, but maybe a slightly different take. First of all, again like everybody else, thanks to the ONC team for putting together this summary, it is awesome. Second of all, yup, this is definitely the huge elephant and we can tackle different parts of it in different ways.

I had two thoughts specifically on the elephant. One is, just like W3C, we could be set up to tackle specific challenges today and have a bucket list or a better word may be a backlog of other things that we want to tackle over time. And that will give us sort of a way of chewing something now while giving us some leeway for later on. I specifically liked John's comment as well around piecing out push base versus pull base exchange. There may be other pieces of overlap there, actually, such as the standards that are used, particularly for content that we know exist there.

But again, this comes back to how do we want to prioritize and how do we choose which pieces are going to be tackled first? And I like the approach that was just laid out as one starting point, but we somehow need to enumerate those things which we might do right now, before we can actually start picking which...out. Is there a thought for how we should enumerate that, or I don't know if the team has already...Carol and Kory and Kate, I don't know if you guys have already come up with sort of a list that we can start going through and pulling through, or do we start with the summary?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Hey, Jitin, let me jump in before anybody...just to follow on those last two comments.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Yup.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

To me, as a clinician and dealing with 5000 providers that have been trying to do this for 15 years, unfortunately I think number one and number one are the use cases around push and pull. And so the problem is, I don't think you can pick one over the other if you really look into the use cases that are serviced by those approaches. And again, I think that they are different enough on the privacy side that they are subsets.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Oh, I totally agree with you. I just think that there might be other pieces of overlap that we could also consider among them, for example, the C-CDA might be a common component of both. But actually I meant to agree with you, John, I was just adding in other pieces which we could...as you said, there is some overlap and then there's some separation, so you kind of...you might need to think about it separately and that was agreeing with that point.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, I was just saying that from the...the comment on the clinical, pick the clinical priorities, which I totally agree with, I'm just saying the problem is, the...in my mind, the two most important clinical priorities are going to break it down into those two different areas right out of the gate. So, if you pick just one clinical priority, you would either pick push or pull, in my mind, and I think you've got to have both.

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

This is Melissa, I'd like to make another big picture comment before we start going down a list, if I can. I think, and I'm particularly enamored with the idea of the examples that we heard from other industries. I think we healthcare people tend to get into somewhat of a mindset of healthcare exceptionalism, and I certainly fall into that trap as well. But I think we should urge ourselves to look at the other industries and how they started and like Jodi said, look at the big picture of the forest because somehow those systems have changed with the times.

I'm thinking of NACHA in particular and the very beginning ACH transactions and how that has blown up to such a degree and somehow have persisted and still works today, in a much different environment. So I think if we can follow these best practices from other industries, and obviously tinker with it where this particular industry is idiosyncratic, but not fall into the trap of thinking that our industry is 100% different than everybody else who has ever tried to tackle similar problems.

Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense

So this is Elaine Hunolt with the VA and these are all really great comments. But from our perspective there are two things going on. On the one hand there's a real urge and a need for simplification, let's simplify into a couple of use cases, let's take the 20% and really deep dive in 20%, let's figure out how to do this. The problem is, I think on the other end is, nobody can agree what that 20% is or what that one use case is. And what I find in our realm is, what I started doing 5 and 6 years ago as some primary approaches, then surrounding me all the world change and new people came in who didn't get to create and build this and who aren't actually out doing, but simply read the media reports and see the email advertisements.

And now they want to go back out to some of the new bright shiny objects, not realizing that the way this is going to be successful is by taking...trying to make it simple, pick a couple of things, do them well, make sure there's good data content and data quality to make health information exchange useful. So although it's appealing to say let's get governance over the whole world, I still think we're back at how can we converge on a couple of primary solutions if it's push and pull or whatever that is, that we can all agree is a primary, foundational approach to use, so we can help simplify our lives some.

Tim Pletcher, MHA – Executive Director – Michigan Health Information Network Shared Services (MiHIN)

Hi, this is Tim Pletcher and one use case summary...or sorry the summaries were fantastic. Been listening to sort of the dialogue about boiling the ocean and I think it's incumbent that we come up with a process. In Michigan we call this the use case factory and it's the mechanism that we articulate what needs to be done and it's messy, but it allows us to begin to prioritize and allows different groups to be able to prioritize what they want to focus on and see what the pipeline looks like.

And I think in many ways it doesn't matter which ones we start with if we can articulate a process that becomes repeatable versus one-off. And I think that that would be the goal for the governance structure would be to come up with a mechanism that takes use cases that are perhaps push or alert oriented and then migrate into those that require more aggregation type infrastructure to support things like query. Because I think everybody is going to want to do it all, but we need a way for them to make sure they're comparing apples to apples when they talk about things.

So, I think we could pick some of the big ones that have already surfaced like patient matching as infrastructure, but that's not horribly interesting, so you're going to need some functional use cases that motivate the business/clinical folks to come on board. But I think the key is a process that become highly repeatable so that as we learn, we can add new functionality and most importantly, re-prioritize as needs change.

Carol Robinson – Principal – Robinson & Associates Consulting

These have been terrific comments. Are there any more, in terms of specifics that Kate went through on the listening session summaries? Are there any things that you may disagree with that were captured here or that you may feel that weren't captured correctly or that you would like to build on these lists?

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Yeah, this is John Blair again, I...do you want...I mean, I think these have been more general comments, I think they've all been very good. Do you think...do you want some on the specifics on some of those bullets, because I...there are some that I could expand on that some...that would be things that I would have been saying to the presenters, had I been on that second session. But, do you also want...

Carol Robinson – Principal – Robinson & Associates Consulting

I think that would be helpful, John, to be really honest I think we need to make sure that we spend enough time walking through the...we heard a lot of things in those 5 hours of listening sessions. And we don't want to just breeze through the list, even though I know that Kory and...have spent a lot of time drilling this down into a summary. But I think it's worthy of more discussion if you've got those specifics, John. So please, dive in.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

Okay. All right. So, because I just don't want to take all the...too much time here, but I'll try to quickly go through a few notes I made on the summary slides. So, on the cost comment, I mean I can speak more to Direct than I can on the HIE, although we certainly were involved in one for over a decade, and I know what some of those costs were back then, I don't know really where they are now.

But certainly in my...from what I am seeing on usage of Direct as it's rolling out in the market, it's really quickly becoming a commodity on pricing. So, I'm not...I don't see where it's prohibitive in terms of users. In terms of accreditation, again for Direct, I don't really understand where it's a barrier since we now...since there is now, I think, 49 organizations that are in the accreditation process. I don't know that the market could even sustain that once it gets into a true business. So, certainly it's not been a barrier to entry, I don't think, so those are two comments at least on the Direct side.

In terms of workflow re-engineering, I couldn't agree more. And again I'll speak to Direct right now because when you look at transitions of care, after we get through the bumpy road of you had standards there in certification with EHRs, etcetera, but it still is end-to-end across at least 3 or maybe 4 systems. And there are bumps out there. Now since it's being pushed quickly because of MU2, that's being cleaned up pretty quickly, faster than I've ever seen.

But it's bumpy on the transaction side right now but I think at the end of the day for transitions of care, it's all going to be about workflow and the re-engineering...or the designing of the user interfaces. And I'll go back to ePrescribing, because I remember that whole thing rolling out and how many years it took and how badly usage was...and adoption was hurt by the functionality in the early days. It's now much, much, much better and not a barrier, but the same kind of thing, I believe is going to happen on transitions of care because at the end of the day, the real usage, adoption and experience is going to come from that user interface, not the conduit that moves those messages, so a comment on that. And I do believe that the success of transitions of care using Direct is going to be based on how well the sending and receiving side handles that within the EHRs.

And then lastly on address books, and again, I can only speak to Direct on this but, what's evolving, there are really a few components. One, what's the minimum data necessary to allow a provider to find another provider? That's, I think, pretty close to being worked out through DirectTrust and the Directory Workgroup there. The next thing is what will the provider organizations that connect and the EHR vendors that connect to these networks allow, through their contracts, in advancing and exposing and making discoverable the end users? That's another piece. And then what are the agreements and contracts between networks on how this information can be propagated when you share it?

So, those pieces are all important, they're all happening as we speak and as those occur, the sharing is already beginning. Some networks are fully sharing their directories and exposing those to the end users. Now, the Edge protocols on automating the updates and things are not there, but that's in the pipe. I would predict that a year from now, as those things all play out, you will basically have a national directory that each network...that will be identical across the network. So, just...so those are my quick comments to some of those points.

Carol Robinson – Principal – Robinson & Associates Consulting

John, thank you so much. Michelle, how are we doing on time right now for this section of the agenda?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

We're about 5 minutes late.

Carol Robinson – Principal – Robinson & Associates Consulting

Okay. Well then, we should probably move on, unless there are any other burning que...comments that anyone has on the listening session.

Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense

This is Elaine from VA. The only thing I would add is I'm not quite sure how to include the patient-centered comments in context with everything else. I'm not really sure if that's still one approach or whether we need to compartmentalize and specifically address patient access to this data. I'm not quite sure where to put that in.

Carol Robinson – Principal – Robinson & Associates Consulting

I agree. That will be the challenging discussion that we need to make sure that we leave adequate time for in our future meetings as well. Elaine, thank you. Chris, do you want to kick off our next section?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Ah, sure. Thank you, Carol. So kicking off, I just wanted to sum one thing up that I heard in the comments and it was very apparent. The members of the committee were, well, if you talk about this type of exchange, we need to address these issues, if you talk about this type of exchange; we need to address these issues. So we are starting to see that we have...not only do we recognize that there is a great variety of different models, but we also recognizing that the requirements for a governance framework are different, depending what model you're talking about. And I like the fact that in our discussions we have become more transparent about it and describe the model that we're currently talking about otherwise, it becomes less meaningful. So I'm very pleased with how the discussion is going.

So the next section is to discuss the recommendation framework and I don't know whether it's Kory or Kate who will walk us through the slides. But the goal is to review the changes that we have made to the framework, you have all seen it in previous slides, and then discuss it as well. So, can I kick this off?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Yeah, sure. Kory, do you want to run through our charge and a little bit of the feedback we received from the workgroup?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Sure, happy to Kate. So just really wanted to take this, before we dive in to all this, really wanted to go back to the charge and just reiterate because I think it's an important part of the conversation. We're really looking for this group to provide recommendations to ONC about the substance, scope and process we should use to implement an approach to establish the rules of the road necessary for information to flow efficiently across the networks. We know that there's a lot of space in governance, we're really looking for you guys input and suggestions on the process and approach. And I think we heard that in a lot of dialogue about how do we narrow this? And I think that was a really good conversation in the first part of this. So again, we just wanted to put the charge forward as we're kind of walking in to this next part of the discussion. So, next slide.

So to help structure the conversation, we want to lay out a bit of a potential framework to talk through and to have the group discuss and react to. So again, really focusing on the appropriate process and approach for ONC to establish the rules of the road. We recognize that there isn't really time for you guys; we gave you a fairly quick timeline to get recommendations to the Policy Committee. So we recognize there is not time to dive into all the knotty and difficult problems, so we really don't want you to do that as part of this. We want to establish a process for going about that, so that's really, I think, the key area for you guys to focus on and help us understand where your thinking is and where you think we should be going in that area.

So we tried to break it down into a couple broad categories, so understanding the goals that we should be aiming towards for a governance structure. What is the process for deciding what the problems are and what should be the content of kind of an overall governance approach? So, next slide.

So, this piece is really synthesized a little from our 10-year interoperability vision paper that came out a few months ago. And in there, we broke it into chunks of 3-year, 6-year and 10-year goals. So this is just trying to give an overall sense of where ONC is trying to push things through the 10-year, as we've outlined in the 10-year interoperability vision. Just to give you a sense, we see governance as one of the key building blocks to get us towards that interoperability vision, so really wanted to put this forward to get everyone thinking about where the overall goal is and then we want to think about how does governance help us get there.

So, it was one of the five key building blocks that was outlined in the 10-year vision paper, governance was the fifth of the five and we think it is really an important one. Obviously it's not going to address all the things we need to do to get to this interoperability goal, but we have certainly, I think, laid out in that document that we see it as an important and essential piece of our overall roadmap to get to interoperability. So really wanted to provide this to help kind of frame the near-term thinking in anything we need to think about in how we structure our process today, to make sure it's also going to be a viable framework in the future, as we're pushing towards those more long-term goals, such as the learning healthcare system.

So that's a quick run through of those pieces. I don't know, Chris, Carol, do you guys want to stop here and discuss or do you want to jump into the problem list?

Carol Robinson – Principal – Robinson & Associates Consulting

We can...

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I...

Carol Robinson – Principal – Robinson & Associates Consulting

Go right ahead, Chris.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Sorry, Carol. I think you did a fabulous job. I think these are high-level thoughts on how we structure as I think they are clear to me, I am perfectly happy to move on. Carol?

Carol Robinson – Principal – Robinson & Associates Consulting

Sure, that's fine unless there are any really burning comments again that the workgroup has.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Looks like there aren't.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Okay, great. Kate, do you want to run us through the problems?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Sure. So, we'll go to the next slide, we can see that we sent out a problem list, as you guys were all well aware. And we really appreciate everyone's feedback. We really wanted to develop the appropriate governance system and mechanism kind of in line with the problems that we see in the market, that we heard in the listening session and that we've heard from internal and external stakeholders alike. We intend to ensure that the governance system we develop will be suited to address these issues as well as the living system that's adaptive to any emerging and yet to emerge problems.

So, our goal here is not to develop specific recommendations to solve the specific problems that we heard in both the listening session and through this problem list. But to just make sure that those types of problems are considered and provide the context for the framework we put together. Next slide, please.

So we asked the subgroup members to analyze and rank problems within the HIE ecosystem based on the severity and commonness of a problem, whether the problems impact on HIE and private and secure exchange and ONC's ability to solve or improve on the problem through governance. Next slide.

And we got issues, problem lists back, I believe, from about 10 people, which again, we really appreciate everyone's response. We tried to go through and rank responses based on what everyone said and how everyone responded and list the top 5 in each category. So, this page shows the top 5 issues that are preventing or having a negative impact on the quantity of HIEs, so how often health information exchange is happening.

The first one, the number 1 issue that people came back with was a common standard is needed for the discovery of a provider's Direct address across and between HISPs to support provider's achievement of the Meaningful Use ToC requirement. HISPs may offer internal provider directories for their customers, but the nation is lacking a common approach for sharing provider information and keeping it updated between HISPs; so this one is really about provider directories.

The second one is inconsistent laws for sharing health information. The third is...has to do with DirectTrust accreditation, it is not uniformly approached. The cost of accreditation and potential for smaller players who could not afford to undergo that accreditation process effectively get locked out of participating in the DirectTrust community.

The fourth issue was that HISPs need to exchange trust anchors in a one-off manner or participate in common trust bundles for their participation...for their participants to be able to exchange with one another. Multiple trust bundles exist today and are tied to differing trust and security policies. And the fifth one is that data intermediaries and providers have varying patient matching standards and methods. And I think Carol had some additional analysis and observations of our top 5, if you want to go ahead and share them.

Carol Robinson – Principal – Robinson & Associates Consulting

Oh, you put me on the spot here.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

If you don't want to now, you don't...

Carol Robinson – Principal – Robinson & Associates Consulting

Yeah, well let's go through all of them and then I'll...I think I'll just contribute as a workgroup member.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Okay.

M

May I ask just a quick question?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

(Indiscernible)

M

On the very first, the very first bullet.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Yeah.

M

As I read that, it occurs to me now that that would be a marvelously transportable concept if it actually said electronic service information...

W

Yeah.

M

...in addition to just the Direct address, because that would make it scalable across the Direct community as well as the other places people keep their information. And so I...

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Right, and non-directed exchange more generally.

M

...yeah, I mean because it's absolutely an issue with Direct, but it's more generically an issue with really discovering electronic service information. And for better or for worse, there was a time when we had...we invented URLs or now URIs because there were different ways to get at information. And I think the concept of electronic service information versus just using Direct or getting...some of the other ways that we get asked data maybe through eHealth Exchange, etcetera, with a UDDI kind of service. That's really something that needs to be combined and get off just the address book only mindset, because it's a much more generic problem.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Yeah, that's definitely true and I'm sure some...work members listed this as the top issue that is impeding exchange, then broadening the scope of the bullet point will only further...

M

And that would allow that first bullet item to cross both communities.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Yeah, definitely, we can update that and I think that's an easy kind of, and more inclusive fix, so thank you for that feedback. We can go to the next slide now.

Under this kind of sub-ranking group, we asked individuals to indicate the iss...or prioritize the issues impacting the private, secure and safe electronic exchange of information and these are the top 5 issues that we heard back. Number one, that data intermediaries and providers have varying patient matching standards and methods. That encryption is not applied consistently to data in motion during data transmission. That data intermediaries do not use a shared set or minimum standard of authentication practices for users when they access electronic data, and this is discussing single versus two-factor versus multi-factor authentication.

That data intermediaries do not use the same ID proofing practices, level of assurance for data users. And this relates to both individuals and to care providers, so while we know that the level of assurance may need to be different for individuals and for care providers, in both of those arenas they're not addressed uniformly. And finally, that data holders need the ability to affirm that the data requestor has or will have a direct treatment relationship with a patient and has the legal authority and is otherwise authorized to obtain the data. So, I will pause there if anyone has any comments or observations on the privacy and security related issues.

Melissa M. Goldstein, JD – Associate Professor Department of Health Policy – George Washington University

Hi, this is Melissa Goldstein. My comment is actually related to the first sort of bucket list and I'm not sure whether you want this comment now or later, but, the bullet point about inconsistent laws regarding consent. I think it might be helpful for this group not to focus on inconsistent state laws since they are laws and in the absence of us asking ONC to try to do a federal consent model, which seems unlikely. I think it would be more useful for us to think about inconsistent consent policies across organizations since policies can be changed on the organizational level, but organizations cannot change their state laws, at least right now. And I'm not sure whether you wanted to hear that now or later, but I thought I would just go ahead and...in.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Well thank you Melissa, that's really helpful. If and when we go to the next slide, we have a list of the items that individuals thought that ONC was best placed or poised to impact and I will say that one of the top issues was the difference in state privacy laws. And I removed that from the list in our PowerPoint slide because as you said, ONC has such a little ability to kind of impact that on a state level or have any kind of positive change with state, from our perspective at least, policies and regulations and laws. So I did remove that and it's certainly an issue that we might need to dive into a little bit further, to get everyone a little bit more onboard and understanding of the complicated issues at play there.

But, if that's it, we can definitely start in on slide 19. As the slide indicates, we asked people to rank what ONC is best situated to improve through governance, policies, programs or recommendations and folks on the subgroup said that those areas were data intermediaries not using the same ID proofing and level or assurance for data users, for data intermediaries and providers having varying patient matching standards. For differing approaches on how data holders should respond to queries, so if an HIO has data on a patient, but the requestor is not an authorized person to access it, acknowledging that the existence of a record would be disclosing PHI and obviously shouldn't happen, but often times stakeholders and entities approach that issue very differently.

That data intermediaries do not use a shared minimum set of authentication practices for users when they access electronic data. And that HISPs need to exchange trust anchors in a one-off manner, to participate in a common trust bundle. So as we can see, a lot of these were privacy and security related issues, for whatever reason folks feel like ONC is best poised to address those and we'd love to hear some more of your feedback on why individuals may have voted that way or what kind of additional context they'd like to provide. So with that, I will open it up for discussion on our problem list.

Carol Robinson – Principal – Robinson & Associates Consulting

Kate, thank you. And this is Carol, I would just start off, as Kate indicated. I took quite a bit of time studying the ten answers across every problem list and in the way that we segmented that prioritization exercise. And there were some of the problems where I would say the workgroup had very consistent approaches or philosophies in ranking those problems on that 1-5 scale that we inserted for that. And I would add that I don't think this was a scientifically perfect exercise and nor do I think that we could have designed a scientifically perfect exercise to drill down into some of those questions. But, I also was surprised in some of the areas at the variability of the...I might not have expected that variability to be as wide as it was. And so, I guess I would open it up for comment, and if you have a...the opportunity to look back at what you sent in or the aggregation that was sent out a week and a half or so ago of all of our answers. If you could think about maybe or comment on different areas where maybe you were not completely clear, in terms of the way the question was or how you might have been confused about your answer. And I think that I struggled with it in some of the questions and I think I'd like to hear if anyone else did as well. Thanks. No one, really?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Well, I think I kind of...this is Chris, Carol, I think I said...I alluded to my challenges in the past. I think that we are being asked to govern something here that is immensely complex, has a multitude of functioning systems that all have different requirements and needs and different type of users and incentive models. And I am...I was really not that surprised by the great variety of responses, because depending on who you ask, the incentive models, based on the model that is being used for that person for HIE, the incentive models are very different and the utility of any ONC intervention is very different. And I think this is a theme that has been immensely apparent in the listening sessions and it continues in this exercise.

Carol Robinson – Principal – Robinson & Associates Consulting

Well, I'll definitely agree with that Chris, and I think that's really well said. So I will just press a little harder and see if we can get any responses and then I'll drop the rope if that's the preference as well.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Hey Carol?

Carol Robinson – Principal – Robinson & Associates Consulting

Yeah.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

I'm sorry, I'm happy to at least take a stab in. So I think...

Carol Robinson – Principal – Robinson & Associates Consulting

Okay, that's great. One of my questions specifically was around one of the questions about encryption and we had some pretty...a wide variety of answers around the requirements for encryption at rest, particularly. And so, Jitin, in terms of that answer or any others where you felt like there might...you were seeing variability, I'd love to hear that.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

So actually...so I was going to...the way I was thinking about this, as we look at this list on the PowerPoint right now, sometimes it's hard to look at this list and try to recall where exactly it fit in...into the answers that we gave, now what, about two weeks ago, which was a very lengthy set of issues that was seen as so meticulously put together. One thing that strikes me as I look at this is that it's hard to answer some of these in a vacuum unless you have the context of...when I think as Kory first presented all the set of problems that ONC had researched that are affecting HIE today, they were bucketed. And that bucketing itself was actually very helpful and it provides context around some of these issues.

So for example, there are a couple of issues here, to John Blair's point earlier, that are very Direct focused and others which are query focused. And so sometimes looking at them and putting them on one PowerPoint makes it a little difficult to remember why we would have considered one more important than the other. I mean, apart from that, I...how would you like us to try to delve into where some of these issues are? The one thing that struck me as missing on this PowerPoint, at least I would have expected it, but maybe it was just I'm in the minority, is there's a lot that ONC can do to foster a continuous improvement and incremental improvement to standards to get over that bumpy road ahead of us for those use cases which have already been highly prioritized and actually hypothetically out there in the world, like transitions of care. But they're not actually happening, but we all agree are supercritical. That's one thing I would have expected to see up here, and I guess I'm wrong and that's where maybe the variability is interesting to explore, why would that not be up here?

Carol Robinson – Principal – Robinson & Associates Consulting

So when you say, Jitin, the variability of standards, are you talking about the requirements of the certified EHR systems or were you talking about...?

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Well, so I guess I'm looking at the original list that we all submitted.

Carol Robinson – Principal – Robinson & Associates Consulting

Um hmm.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

I've not pulled up everybody's answers, I've only pulled up mine at the moment. And actually it relies...I don't actually see a question corresponding to something we heard in the listening session which is the variability in some standards, Direct particularly, C-CDA, another one. Maybe there are others, but I know at least those two, is what's hampering health information exchange today and there's a lot ONC can do about that. I don't see it in the original set of problems and I'd love to know, was there variation around that or was it just actually not posed as one of those problems that Kory and the team unearthed as they looked at health information exchange? Maybe that's...information we got through the listening session.

Carol Robinson – Principal – Robinson & Associates Consulting

Kor...maybe that's something Jodi or Kate or Kory want to answer?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

So, this is Kory. I'd be happy to jump in on that question. So when we put this list of problems together, we really focused on governance problems in particular. So to us, a lot of the times that's more the policy side of the fence and I think when you look at the 10-year interoperability vision and the five building blocks, there are certainly many of the building blocks that are very focused in on the standards piece. And we've recognized that there are a lot of things that need to happen on the standards side, but when we talk about governance, we usually focus more on the policy side. So that's why you don't see that particular problem in there that I think we all recognize as a key issue in the industry.

Barclay P. Butler, PhD – Defense Health Agency

Hi, this is Barclay. If I could jump in, on slide 15 I think you hinted to it. On slide 15 the last bullet says, the goal is not to develop recommendations for the specific resolutions of the problems, but really to create a governance system that can address these issues. So maybe we look at the variability that we're seeing in the issues and we use that variability, that scope, that broadness as a test of the governance structure that we build, in order to be able to address that broad scope. Thoughts?

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Yeah, hi, this is Jitin. Yeah, actually I agree and actually I think I agree with both points, it's...it becomes a little tricky for me because I think about standards as sort of very concrete things and that's clearly not what we're supposed to be tackling over here. But at the same time, the issue that they are creating is not that C-CDA needs a new version and there's an element missing or something like that, although that is true. What the problem is, there is no mechanism that exists for continuously updating these things and improving them over the course of evolution of the industry. And that's where...that in my mind is a standards problem, but it's also a governance/policy problem, and that's where I was a little confused Kory.

So, I'm happy to draw a line and say, hey, that's just not part of it and then offline, kind of understand where does that happen. Because that's probably more...in the very near term, that's probably more important than almost anything else we do on the policy front, but all the policy things are going...is what's going to enable us to have information exchange and meet the 3, 5 and 10-year plans which I'm wholly on board.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I'm going to take the Co-Chair prerogative and remind us that we only have 16 minutes left until the public comment session and we are...we still have to review the modified straw man.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

I'm happy to table this until later.

Carol Robinson – Principal – Robinson & Associates Consulting

I think that's fair. But I...and perhaps there's a way that we can devise some additional feedback in terms of what the conversation has unearthed. So thank you Jitin and Barclay. And Chris, I'll turn it back to you to move on.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

So, I don't know if Kory or Kate want to start off with this one, but one of the things that we have had a heated debate over in the last couple of days is, the recognition that one model doesn't fit it all. And it is...it has become clear to us that when we talk about the governance that we...a governance framework that is exchange specific. So, in...we've...multiple time...appreciate everybody who made that comment that...

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

Chris, this is Michelle, you're breaking up pretty bad, we can't really hear you anymore.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I apologize, I'm going to switch phones. Let me do that right now. Is this better?

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

Yes, thank you.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Okay. So, that multiple people on today's call said that this is an area that we are asked to develop a governance framework for that has a great variety of models that all have different needs when it comes to guiding and governance and monitoring it. And so in slide number 21, what you see is that we realize that we need to break this up when we are developing a governance framework with an eye on the different exchange models that are available out there. However, that doesn't mean we have to reinvent everything for every model. There might be components, functionalities that are required, standards that are required for one particular model that then can be recycled in another exchange model and can be used across more than one model.

And so with that, and I think we can go to the next slide where we are talking about the individual processes on each of those different models that would allow us to do the governance. Can you advance to slide 22, oh, I'm sorry, I'm looking on the wrong screen, yeah. Yeah, so that allows us to look at...put together the things that we had talked about, look at the ability to do deeming and then look at the components that are the modules that we need to do those...to implement a governance structure around each particular model.

And so, as you can see, our thinking here has evolved and has evolved because we realize this is such a complexity, we need to break it up, I think somebody said buckets today, also I think I heard chunks. But we need to break it into pieces that have similar structure, similar incentive models, similar approaches to the exchange and identify the need for the governance model for those. So that's really the big change in our thinking over the last couple of days and I think it's critical at this point that we open this up to the group and see if that holds water, if there's something that you think makes sense from a way of thinking at it, from a way of approaching this. Somebody said earlier today, one bite at a time, and yes, we don't want to leave any of the elephant uneaten, but we want to break him...break it up into pieces that we actually can swallow.

So, I'm going to stop talking and see if there are any immediate responses from the group to this. Or maybe Carol, you want to say something about the evolution of our thoughts.

Carol Robinson – Principal – Robinson & Associates Consulting

Not at all, I think you've summarized it terrifically, thanks. Let's get some feedback.

A. John Blair, III, MD, FACS – Chief Executive Officer – MedAllies; President – Taconic IPA

This is John Blair. First of all, I think you did a great job of listening. I think this...I couldn't agree more with what you've done here. I...it could be that as much as 80% of this will overlap across all those different sub-segments or buckets, but I do think there's enough difference for some of it that doing it this way makes a lot of sense. So hopefully, you can capitalize and create efficiencies across all of those and then have, where some of the nuanced differences really create great variation and you just can't fit it in to one place, it will work. But I want to compliment you on this approach.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you. Any other thoughts and criticism is more than welcome.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

This Jitin, just a question really, can we say more about deeming, what we mean by deeming, what the process would be? Or, what it is that we're deeming and why? It's just a term I'm not...I've heard it now a few times and I've heard it being described a few times, but I'm not sure that's actually universally known what that means.

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Sure, can we go back up to the slide that had a little bit of an explanation of our terms? It's one more, I think. If you'll look, the deeming concept is the second one down. We haven't really identified the kind of scope or meat of what the deeming program would look like. But we certainly conceptualize it as kind of establishing the checklist of things that a governance entity would have to do in order to be...in order to like consider it a good governance entity and within the rules of the road of what we think they should be accomplishing.

So it would probably be some kind of lightweight and easy to interact with program that ONC could facilitate or run or have an outside entity do that would review that entities kind of program and where they're going and either deem it or not deem it. And it's established kind of purposefully as a kind of amorphous concept at this point, because we would really look to you guys to fill in the holes of what that would look like and what kinds of things it would be important to include in our deeming program. And we chose not to use a term of our...like accreditation or certification, because we know those things have such a heavy lift associated with them and are a little more...than we'd like this program to be.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Thanks for adding that last piece. This is Jitin again. So are we going to at some point in this group delve more into what deeming should look like and what monitoring, for example, oh, and actually even guidance, what should each of these pieces really look like?

Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology

Yeah, I mean absolutely to the extent that we can agree that all of these things need to be a part of the process and how they kind of fit together in a larger framework, then we are more than happy to get started on the substance of what a deeming program need or need not include.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Right. Okay, thank you.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Are there any more thoughts on the model?

Carol Robinson – Principal – Robinson & Associates Consulting

Chris, I know that as you and I have talked and emailed extensively over the past several days, it's been a...you happen to have a process within your thinking that takes time. And so, I think that in alluding to the rigor of the request of this subgroup and the timeframe that we have in front of us, the goal for this meeting was to get through this summary and present the results of the top problem list issues in each category. And then look back at the evolution of our thinking in terms of the straw man framework.

The next HIT Policy Committee meeting is a week from tomorrow and they are going to be receiving a report on our...the subgroup's progress thus far. And so, any kind of comments that you can provide me with in terms of being able to develop that, together with Chris, over the next couple of days before he jets out of the country and leaves me to present on both of our behalves and your behalf as a subgroup next Wednesday. How would you categories or how would you describe our group thinking and progress thus far in terms of this governance framework and then knowing that as Jitin very astutely asked, that the next 3 meetings that we have scheduled for September, we'll be diving down a little bit deeper into all those details. So, we only have a couple of minutes for those comments, but if anyone has a comment in terms of your feelings about our progress, please feel free to share.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

We must have done a good job.

Tim Pletcher, MHA – Executive Director – Michigan Health Information Network Shared Services (MiHIN)

Yeah, I think you've done a phenomenal...to get to here for somebody called it boiling the ocean or eating an elephant or something. This is a Herculean task. I think what might be interesting, in terms of constraints, is what...we are bound by what ONC is authorized to be able to do. And so I think that that is a constraint, not necessarily a bad constraint, but a constraint on the process. And I think it's important to note that that is the context that this has to operate under. And given that context, this is a pretty good framework.

Carol Robinson – Principal – Robinson & Associates Consulting

Was that Tim speaking?

Tim Pletcher, MHA – Executive Director – Michigan Health Information Network Shared Services (MiHIN)

Yes, that was Tim.

Carol Robinson – Principal – Robinson & Associates Consulting

Okay, thanks Tim. I thought it was, but I wanted to make sure.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Well, it looks to me that we might not have any more comments. What's the process, Michelle, would we go to the public comments early?

Public Comment

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

Yup, we can open up to the public comment if we are ready. Sounds like we are so, operator, can you please open the lines?

Caitlin Collins – Junior Project Manager – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment please press *1 at this time. We do not have any comment at this time.

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

Okay. Well thank you everyone and we appreciate a great discussion today and we look forward to our next meeting and bringing recommendations to the Policy Committee next week, or at least an initial set of the thoughts coming out of this group.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

And I would like to thank everybody on committee and the ONC staff, they did a tremendous job turning those slides over in the last several days with all the feedback that they received. So, thank you everybody and that was a fantastic call. Thank you.

Carol Robinson – Principal – Robinson & Associates Consulting

Thank you, Chris and thanks to ONC and thanks to the workgroup.

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

Thank you everyone. Have a great day.