



HIT Standards Committee Final Transcript November 18, 2014

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you, good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee. This is a public call and there will be time for public comment at the end of the meeting. As a reminder public comment is limited to 3 minutes for anyone who chooses to comment. Also as a reminder, please state your name before speaking as this meeting is being transcribed and recorded. And because it is a virtual meeting we will be using the virtual hand raising as a reminder to everyone. And with that I will take roll. Jacob Reider?

Jacob Reider, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Jacob. John Halamka?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Present.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, John. Andy Wiesenthal? 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. Anne LeMaistre?

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer - Ascension Health

Present.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Anne. Arien Malec?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Good morning.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Arien. Marty Harris?

C. Martin Harris, MD, MBA – Chief Information Officer - Cleveland Clinic Foundation

Present.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Marty. Charles Romine? Cris Ross? David McCallie?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, David.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Good morning.

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

Dixie Baker?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I'm here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Dixie. Liz Johnson?

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

I'm here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Liz. Eric Rose?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Eric's here.

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

Hi, Eric. Floyd Eisenberg? Jamie Ferguson? Jeremy Delinsky?

Jeremy Delinsky, MBA - Senior Vice President, Chief Technical Officer – Athenahealth, Inc.

Here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Jeremy. John Derr?

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

Good morning.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, John. Jon Perlin? Keith Figlioli? Kim Nolen? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi, Leslie. Lisa Gallagher?

Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy & Security – Healthcare Information & Management Systems Society

Here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Lisa.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Hi.

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

Lorraine Doo?

Lorraine Doo, MSWA, MPH – Senior Policy Advisor - Centers for Medicare & Medicaid Services – Health and Human Services

Yes, I'm here.

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

Hi, Lorraine. Nancy Orvis? Becky Kush?

Rebecca D. Kush, PhD – Founder, Chief Executive Officer, President & Director – Clinical Data Interchange Standards Consortium (CDISC)

Here.

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

Hi, Becky. Sharon Terry? Stan Huff?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Here.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Stan. Steve Brown? Wes Rishel?

Wes Rishel – Independent Consultant

Here.

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

Hi, Wes. Before turning it over to John I just want to mention, and Jacob, I just want to mention it has been a long time coming but probably about a month ago now we officially received word from the Secretary that we had three reappointments to the Standards Committee.

So, if you remember it took a little bit of time but way back early winter, I would say, of this year we had posted three slots on the Standards Committee and we have reappointed Arien Malec, Leslie Kelly Hall and Floyd Eisenberg. So, welcome back and we're lucky to have all three of you join us for three more terms on the committee and with that I will turn it to Jacob.

Jacob Reider, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you, Michelle. I'll make this quick because we have a full and, as many have discussed, short meeting today we're trying to be efficient and focus on quality and not quantity. As some have observed the meeting today is at the same time as the meeting in the American Medical Informatics Association so many I'm sure are huddled in hallways talking into their phones trying to shield all of us from the noise and the excitement at AMIA so thank you to those of you who are doing that. I managed to find a desk somewhere nearby.

And it's an exciting time and I would reflect on something that came up at a session that I was in about an hour and a half ago because I think it is relevant to some of the conversations that we've been having over the past 6-8 months and it has to do with what's the lever that will be leveraged in order to quote "get everyone using the standards" and as Doug Fridsma used to say, you know, the nice thing about standards is that there are so many of them, right?

One of the attendees at this meeting stood up and asked, well, we've had all these standards, the meeting was about decision support and clinical quality improvement, and he said "we've had all these standards for years that are in the domain of CDS and quality improvement and yet the Health IT developers haven't implemented these things" so we were talking about hardened syntax or GELLO, or other things and the question was "well what makes you people think that things are going to be different now" and I was struck by the answer that came out of my mouth and a couple of others, one is that the technology hasn't been ready and there haven't been as compelling reasons for care providers to make the best decisions for their patients as there are today.

And so I think with the convergence of the delivery system reform efforts that have been initiated by the Secretary and really being carried forward by CMS we are seeing both in the public sector and the private sector I think a new and probably persistent push toward value rather than volume.

And that means that better decisions need to be made and the quality of care that one provides is actually going to change the way that one is compensated. I think that is a compelling difference and may represent a piece of the tipping point for how we move forward and so in order to do the things that need to be done the right standards need to be in place.

It does not necessarily mean that the right standards are enforced by the federal government. It means that the right standards need to be in place. And so I think its great work from this group and of course its predecessors that has gotten us to where we are where there are good efforts that are happening both between the private sector and the public sector to cause these efforts to be aligned and in place.

I want to make two other points and then I'll shut up and pass the baton onto John, one is that you may notice in some of the way that we at ONC have been talking about things in the last six or eight months that we try and talk about Health IT instead of EHR and that the EHR is perhaps the eversion of a manila folder or a file cabinet and by calling it a record we don't remind folks of the dynamic nature of this tool that can be used to make our care delivery better and more efficient and less error-prone. I think it's an important component of how we look at this that we described this as Health IT overall rather than an electronic health record.

And the other point, which we make every time and I want to fulfill my promise to myself to make the point again today, is that the Meaningful Use Incentive Program is yet...is simply one of a handful of opportunities of policy levers that would reference certified health information technology and we've seen this most recently in the chronic care management component of the physician's fee schedule that was published by CMS about 10 days ago and therein there is reference to certified health information technology and if folks use certified Health IT they can submit the chronic care management fee and obtain chronic care management reimbursement from CMS.

This is one of what is perhaps many opportunities for both the federal government and states, and the private sector to reference certified health information technology in their policy programs to encourage better care at lower cost. So, on to you John, and thanks so much for everybody being here today.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, thanks so much and before we go on to the minutes and the review of the agenda I think all of us on the phone have to give a virtual toast to Jacob Reider because Jacob Reider after years of selfless service to ONC will be returning to other opportunities shortly. I'm not certain of the exact timing of that I'm sure Michelle you know but I just want to thank Jacob because he has been both an informatician's informatician as well as a good friend to us all. So, can we give a virtual round of applause to Jacob?

Applause

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yay.

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

And this is Jodi Daniel if I may just jump in for a second, I just want to also publicly give my personal thanks to Jacob Reider he's been...we've worked in various capacities at ONC with each other and he has been a true leader, he has provided such great context and support for a lot of the work that we've been pushing over the last decade and he's also been a great friend and I wish him the greatest of success in his future endeavors and I'm sure he'll be close to all of us still and helping to support ONC's mission from wherever he lands. So, thank you Jacob.

Jacob Reider, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you Jodi, thank you John very kind of both of you and of course unnecessary.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And all I can say Jacob is I will regret not being able to be on the phone with you as you are on Acela and I can hear the announcement at every stop as you go from New York to Washington.

Well, so today we do have several, as Jacob has said, items that are quite rich but a time that is short and we'll hear from Charles Parisot what I'm going to call the Wes Rishel problem of how is it that we can do asynchronous C-CDA exchange when there are different versions of different templates at different times knowing that at no time will we have complete homogeneity of the payloads over the wire that are exchanged between EHRs. So, Charles Parisot will review for us the input from EHRA in reviewing the various C-CDA versions and their compatibility with various products so that should be very interesting for us all.

And then we will hear from Evelyn Gallego from the standards interoperability framework about electronic long-term services and support and this is actually going to be an interesting topic because I hadn't realized that as part of ACA congress provided incentives to promote the use of community-based long-term services and support and specifically incentives for individuals with physical, cognitive and mental impairments who have lost the ability to function independently and so this whole theme, as I think Jacob has just told us, is not just EHRs it's healthcare IT and where does this element of healthcare IT fit into our ecosystem? So, look forward to that.

And then we'll hear from Steve Posnack about the latest and greatest certification edition release two test procedures and various pilots but also we'll hear from him about ONC's FHIR efforts and so for those of you at AMIA, because in our...as we got onto the phone I heard just the general amazing amount of stakeholder excitement about Fast Healthcare Interoperability Resources and I'm seeing it in academia, industry, government that there seem to be so many individuals believing that the query/retrieve capabilities of FHIR combined with the simplicity of its implementation and the use of security enforcement such as OAuth and OpenID and RESTful transport gives us the potential of aligning ourselves with the agility of a Facebook or Google and an Amazon as opposed to requiring PhD's in informatics to implement interoperability.

So I think this is going to be very interesting not only to capture what was going on at ONC but also to reflect how the private sector can help with acceleration of FHIR efforts as we look forward to life beyond Meaningful Use as Jacob said.

Meaningful Use is only one of our many drivers, certainly the ACA and the utility and in fact the business imperative of exchanging health information will drive us I think to adopt FHIR pretty quickly.

And then we'll hear from Julie Chua on the S&I Framework data provenance use case and recognizing that data provenance is quite hard and Gary Dickinson is often telling us that we should ensure integrity of data from its point of origin to its point of use and it can get quite complicated because you could go from start point to endpoint or start point to transmitter to endpoint, or start point to aggregator composer to endpoint and so how do you maintain the provenance and integrity of the data as it goes through various intermediaries from the clinician who wrote it to the clinician who consumes it? So we will hear about that.

And then Steve Posnack will talk to us about where we are in our Workgroup reformation and as we think about aligning the Workgroups with the work ahead which includes looking at the 10-year road map and looking at Meaningful Use Stage 3 NPRMs and these kinds of things.

So, going to be, I think, a very rich meeting worthwhile for those joining from desks at AMIA, but I'll just reflect that at a time when we have so many things going on in the world and we have so many issues of politics across the world, economic challenges, I've lived in the standard's world for almost 20 years and I think that it's time for this optimism that I write about because with all of us on the phone and working on the Standards Committee so hard I have never seen the perfect storm that seems to be forming around the need for interoperability, the technical capacity to do it and the policies that enable it. So 2015 as we head forward will be a great year.

So let me turn it back to Michelle and I think Michelle you did want me to do one last thing. Were there any comments on the minutes of September 10th and October 15th?

Well, no comments being heard then we will approve those by consensus and Michelle I'll turn it back to you for Charles Parisot's presentation.

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

Thanks, John. Charles are you ready to go?

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

I'm absolutely ready can you hear me?

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

We can hear you.

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

Thank you.

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

So, you can just tell us, next slide, and we'll move along for you.

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

Okay, that's great. Thank you very much for inviting EHRA to present on the analysis that was done on the "Wes Rishel problem" as John said. Migration cutover two-way cutover and we have some interesting findings and recommendations that could help the nation move forward as C-CDA continues to grow and to evolve. Next slide.

So what we have here is a result of a set of questions that were devised and asked to all of the members of the EHR Vendor Association. The same set of questions we give them a test C-CDA that you will see was used to actually provide some actual implementation feedback and this was really the intent of this effort which is not to be an intellectual effort but to really answer the question what if we were introducing a new release of C-CDA today 2.0 what would the existing product do, react, not do, do well, not do well?

Out of the less than 40 members of EHRA we had...

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

Charles, we just lost you.

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

I should be back my phone fell on the floor. Can you hear me?

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

We can hear you.

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

Okay, sorry about that. So, we have 26 vendor's responding and those responses are collecting and make the statistics of what you have here.

Clearly, you will see that there are different styles of implementation approaches, some very conservative approaches, some more aggressive approaches and that created a range of behavior that we should be able to appreciate with the analysis on those answers.

The other lesson, which is important here, is this is not a C-CDA specific problem. This is a problem that does exist when you migrate messages and get new versions, at least you probably will also have to deal with when we moved to FHIR as we are considering this as a future step. So, a lot of lessons here have to be taken as broader than C-CDA and we think this is why this exercise was quite useful. Next slide.

So the first question was if you receive a C-CDA with a template ID you do not recognize, this is typically the case where an existing implementation would receive a new version what would your EHR do?

Seventy-nine would store and only 66 will display and we will see some further refinement about this just below. We would have a document that failed to be viewable which is rather embarrassing. Content to be rejected which may be difficult but not that challenging. And an alert erased which would make the life of a clinician a little bit more worrisome for a smaller number of them.

So, it becomes very clear with simply this first question that we need to make the existing receiver far more educated and able to deal with future versions and be future proof in a sense, which unfortunately was not necessarily well specified nor well agreed around the C-CDA standard. Let's get a little deeper with the next slide.

In this next slide the second challenge is that the C-CDA release 2 has become more robust in terms of identifying the versions of the template and has added an extension attribute in order to provide a sub version number and the answer there is would you distinguish between the current version which is a single number and the new version that has two parts to the version number, and you see that there would be issues here. For the majority, a large majority it would either consider that the first part is the only thing meaningful and ignore the second part, it would not even realize that there is a second part. So, this is definitely something that needs to be addressed and the sooner the better. Next.

The ID, and you will see this ID coming back, is to say, hey, what if a new system would actually format a same CDA document and would make it in such a way that the relevant part would comply with the template ID of the current version, the release 1.1 and the document would also comply with the release 2.0 which is the future version.

And the point here is very interesting, 80% of the system would support this and we had however a caveat that a number of implementers made which is to say you know there are a few things that have been changed in C-CDA 2.0 that really could have been changed in a way that is much more friendly to the prior version and would allow the amount of information that is in both to be a closer to 100% coverage.

So a suggestion that you will see comes back which is there maybe a little more design thoughts that need to be applied to the C-CDA 2.0 in the way a number of things that were currently supported are designed and guided for implementation even more with a backward compatible way in a sense. Next.

The question here is more checking the behavior of the system that receives a C-CDA 2.0 that claims to not comply with the 1.1 specification, so there is no template ID for 1.1 it's a pure 2.0 version and we see that a fairly large percentage of the 26 EHRs would actually be able to accept it and display it.

However, this percentage diminishes seriously, down to 60%, when it comes time to actually process it and this is a theme we are finding implementers are fairly liberal when it comes to accessing, accepting and displaying but become a little more tight when it comes to actually processing and importing the information for clinical use.

So we have the same statement as we heard before that says, hey, if you could reduce at the bare minimum the cases where this is really new information in the 2.0 that therefore would not be dealt with by a 1.1 version this would make the transition much smoother. Next slide.

We now have the dynamic and trying to push the mindset of the implementers as to how...what would you do if you have a product that does CDA 1.1, how would you support 2.0? Would you retain the capability, would you only support 2.0, would you be able to trigger and keep the same problem, medication, allergy reconciliation capabilities and how would you deal with the even older version the CCR and the C32?

You see there the commitment I would say to say, yes if we do a release 2 we will still continue to support the release 1.1 as it is defined so we are going to, in a sense, move forward and not lose what we knew how to do.

However, there was a little bit of a more negative stance of saying, hey, you know, aligning four versions now is becoming a little bit of a burden, could we, in a sense, reduce and simplify the implementation and the re-testing for CCR and possibly C32, so an ID that to say, let's have a window of cutover but let's move that window and cut the older branches if at all possible. Next slide.

Now we take the case of a vendor who is, in a sense, new on the market and on Meaningful Use and that implements and only release 2.0, would you work to add release 1.1 to your product and we had a question as to, you know, with the cost of doing the only new one versus doing both the one and the previous one, most implementers there said "I don't think this is a major effort to actually build both versions in a new product that I would bring to the market." So, an interesting indication here on the flexibility of the mindset that vendors have. Next.

The straight question now being asked is okay one way to do that cutover is as senders send you both, a new sender would send an older version compliant and a new version compliant to the 2.0 and we will actually ship both and allow the receiver to pick the version that it likes best. And we had a fairly strong voice here 19 out of 26 that said “we don’t like this sending the same content in two versions is a bad idea this is going to create complexities in terms of testing a number of possibly duplicate data.” So that was not well received at all by the implementers. Next.

And we’re reaching towards the end here. The conclusion that we are suggesting and that we drew out of this exercise is to say, okay there is work to be done. The first thing is maybe your last look with a backwards compatibility, both sides cutover of the new release 2 which is almost finished really is something we need to spend energy on because this is going to be well spent and something we will get a big return on our investment.

Make sure that all of the sections that are introduced that were absent in 1.1 are added so that they may be ignored by release 1.1 implementation and we don’t create too much disruption on the older type system and have a very clear and explicit strategy into the guide about the use of template ID.

So we want to make the system explicitly intelligent in managing those template IDs so that they make flexible and intelligent choices and deal with the information as best as possible and there is even a suggestion to say we should have backward compatibility tests built into the testing bench so that we are much more robust about what we do and more consistent in terms of product behavior.

So the recommendation here is to say, a little bit of work that in particular HL7 should do with the EHR implementers with a thorough review last round of review on 2.0 and minimize version cutover challenges which seems to be an urgent next task that has to be done in addition to planning things in the future in terms of testing in particular the ability to do that cutover.

This concludes my presentation, thank you very much, and I would be happy to answer questions if any.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Charles thanks so much and it is been a while since we’ve caught up and all that effort you put into HITSP foundations was certainly wonderful so thanks for everything you do.

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

Welcome.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And what’s interesting is, is it Jacob who used the term “let us proceed on the path of least regret” and I think what you’ve highlighted Charles is that as we invented the future we need to be very careful about making decisions that make the past harder and incompatible then it should be or needs to be.

Jacob Reider, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

So, John, would deference to Dr. Fridsma, I’ll have to clarify that that was Doug Fridsma’s saying, I might have parroted it once or twice but Doug needs the attribution.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, so corrected, so thank you. Now, Michelle you have...I think are the keeper of the raised hands so do we have questions?

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

Wes Rishel has a question.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Wes, go ahead.

Wes Rishel – Independent Consultant

Good morning, Charles.

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

Good morning, Wes.

Wes Rishel – Independent Consultant

Or good afternoon depending on where you are or evening.

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

From Florida it's not sunny but I'm there.

Wes Rishel – Independent Consultant

Okay, so, I have a couple of questions. One is you talked I think about in effect a window of time after which certified health information technology wouldn't be required to receive older versions. Did I understand that correctly and if so do you have a sense of how long that window, how wide that window needs to be?

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

The sense is always being able to receive, always being able to display but to basically close the window on actually processing and importing these data.

Wes Rishel – Independent Consultant

Okay.

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

And the reason is because we want to make sure that the clinician always has access to information, it is not possible to not do that. However, the effort to actually do the import processing is the one where we can bring some simplicity. No definite start here but definitely you know two versions back sounds like a good move.

Wes Rishel – Independent Consultant

So two versions back in terms of versions of the standard or updated certification testing releases which we might have called Meaningful Use stages back before we got educated, what would represent a version in that view?

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

Definitely the version about the certification criteria, the release 1.1, release 2.0 of C-CDA, you know, at the level of the implementation guide, not the level of the small adjustment that we do in terms of testing.

Wes Rishel – Independent Consultant

Okay, now if current certified HIT which we think of right now as EHRs were to start to ignore sections that were added to 1.1 for the purpose of their being ignored wouldn't that itself represent a change in the operation of those EHRs that require development and testing?

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

Wes, I am not 100% sure that I understand, so you are assuming that an older version let's say for example a release 1.1 would receive a release 2.0 of C-CDA in which there is a new section and entries for which the release 1.1 implementation has not been programmed. I believe that this is probably unavoidable at the processing level and as we've seen we have a large number of EHRs that would be able to display the content of that information. But we have about 40% of the EHRs that would not be able to actually process and import that information.

Wes Rishel – Independent Consultant

Okay, well I may have misunderstood. I thought that at one point you had discussed adding in effect identified syntax to 1.1 so that this could be recognized and ignored, so that sections could be recognized and ignored rather than treated as an error.

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

Correct, correct.

Wes Rishel – Independent Consultant

All right, so in order for that to be effective then I would understand that the certified HIT would have to have a new version that included the updated schemas and other syntax recognition for 1.1 to achieve the effect that we're trying to get here.

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

If I may, we have the...we don't want to generate unnecessary failures or alerts on systems.

Wes Rishel – Independent Consultant

Right.

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

Which is what we are discussing now.

Wes Rishel – Independent Consultant

Yes.

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

So, if those older EHRs would not be updated and the physician would be faced with alerts or errors saying, sorry I cannot process this, you cannot import that document, and knowing things at the operational level, and yes a product would need to be updated to, I would say, smoothen their behavior. I would certainly not mandate this but I would say encourage this as a, you know, existing customer improvement.

Wes Rishel – Independent Consultant

Okay, so, I think at a minimum it is an almost trivial change to the older versions of the certified HIT but it does require...to achieve the kindness to the physicians it does require that all of the customers go through a version upgrade, some of them probably do that anyway routinely and others it may...I guess it would be an incentive for them to get up-to-date on the vendor software. Thank you.

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

Yes.

Wes Rishel – Independent Consultant

I wanted to say that I strongly support your recommendations that certification and any other compliance testing whether it be done to officially get a ticket or whether it be simply widely recognized as a way to avoid to certified interoperable implementations not interoperating that they all include testing scenarios for the inter-version compatibility that you're recommending here and that they include testing scenarios for the handling of errors, what might be called incorrect sending or wrong version sending or anything like that, so that we know that the behavior of those systems is manageable as opposed to being bewildering to the users. So, thank you very much.

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

Welcome.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, thanks very much, Wes. As I reflect on some of the certification work we've had to do in Massachusetts where we had some senders with C32 documents and some with C-CDAs and each of those C-CDAs is implemented in a slightly different way and you do ask yourself the question, what should be the expected capabilities of the EHR when encountering a deprecated standard? Should it be that C-CDA 1.1 and forward become structured data import but C32 and before becomes simply a human readable document with no structured data import possible or such things to be decided in certification?

Wes Rishel – Independent Consultant

John, you raise an interesting issue that I think would help inform, this is Wes again, that would help inform how we would recommend ONC go forward and that is the extent to which older versions of CDA-based work products are actually being used for structural imports at this time.

In my time with Gartner as I talked to vendors and health information exchanges, and end-users I found that almost all of the success stories around interoperability involved importing a CCD or CDA document and then treating it as a smart text report, smart in the sense that there was enough structured information up front to automatically associate it with the right patient and insert it into the workflow and so forth.

But that the actual content, clinical content, was going to be inferred by a person looking at the display version of the report rather than automatically imported into the detailed clinical database. If we can somehow find that there is only a nominal amount of structured importing going on right now we might be able to identify a cleaner strategy with less effort spent on compatibility with older versions of HIEs, thanks.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Sure and so Wes to your comment, we have actually done audits as we are requiring many physicians to submit some CDA form for quality measures and what we are discovering is that where there is optionality in older deprecated versions it is very challenging to get consistent structured data extracts to populate registries and quality measurement tools. So, I think you're right there's an interesting balance to be struck in certification as to what becomes true structured data and what becomes human readable for care coordination.

Wes Rishel – Independent Consultant

So, as the working proposition I would say let's propose that all of the issues related to inter-version compatibility start with release 2 unless someone can make the case that they're going to be hurt because they're doing a lot of imports from release 1.1-based artifacts. That's kind of a sharp question but it's a way to streamline how we would go forward.

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

Wes, Charles here. This is a question that...and if the HIT Standards Committee has more such questions EHRA would be very much willing, you know, to take those questions and run it through the same group and provide you and ONC additional feedback because I believe that this is reality. We need to actually develop something that is anchored in reality of actual implementation, actual product and actual clinical practice.

Wes Rishel – Independent Consultant

I would certainly ask the leadership of our committee to make a request like that to EHRA I can't do it myself, but I would add to that that we should seek input from the end-users as well because it can work that a vendor knows, and I was a vendor so I know this, knows they have a certain capability and doesn't have a detailed track on how many of their user organizations are actually using that capability, so in this case a vendor who has the ability to import data we're actually interested in if their users have been using that feature overtime.

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

Especially as Meaningful Use...the criteria of requiring you to import data and we are being tested for that. So, you're correct if you ask the product they do and they have to. What is the level of usage is really the question, yes.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well very good points and Jacob, you know, I would imagine that folks at ONC might say, as Charles has may be offer, want to follow up and get such feedback as to as future regulation writing occurs might there be a natural cutover point at which we begin this sort of backwards compatible tracking and certification?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

John, this is Eric Rose, I apologize for speaking out of turn but...

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

No, please?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

I'm joining by phone so can't raise my hand. I wondered if I could ask a question of Charles?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Please.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Yes, so this is Eric Rose, I was surprised that so few...that there seems to be such an obstacle to rendering the C-CDA as a human readable document and I wondered if you could educate us about why that's a problem. I thought that the template IDs reference...from those it's possible to extract I don't know if it's style sheets or something that would direct how to present the documents for human readability and I'm wondering how...if you could advise us on how deeply an obstacle that would be to overcome because the human readable rendering would be...would go a long way towards addressing the concerns for practicing physicians at least.

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

All right, the principal you propose is definitely consistent with what we propose, where we say, ensuring that older versions can always be brought into the system and displayed with the necessary style sheet and displayed completely is definitely something that we need to keep and I think I have an extremely high percentage of the vendors, if not 100%, that says "yes, will for sure display the past." This is not a problem.

So the problem with display comes with the older version receiving a new version of C-CDA and there you are now using an older style sheet applied to a newer version and the number of systems are somewhat conservative because they probably do not know exactly what is going to happen when you provide more information into an older style sheet and will it keep, will it be incomplete, will it be misleading?

So I would suspect that this is probably one of the reasons why this percentage is apparently low but we have not dug deep into that question.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Thank you that helps a lot.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you, well, Michelle, are there others in queue?

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

No one else is in the queue.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Charles you were just so clear in your presentation that you had no controversy.

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

A pleasure.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes, indeed, so I think as our follow-up we may, because this is such an important topic and Wes has raised it on a couple of occasions, have a path forward as to how this could actually appear in a future rule based on guidance from all those that have to comply with the future rule. So, thanks again.

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

Thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, well, next I think Michelle we are now queued up to hear from Evelyn on the long-term services and support initiative.

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

Hello, Evelyn?

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Yes, can you hear me?

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

We can hear you.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Wonderful, well, thank you very much and good afternoon everyone or good morning. I'm delighted to be here today to introduce you to this new exciting initiative sponsored by CMS titled the electronic long-term services and supports initiative, which I will refer to as the eLTSS initiative. If we go to the next slide, please.

So, our outline for today there is lots of content in this presentation so I'm going to do my best to run through it quickly to ensure we have sufficient time for Q&A. Next slide.

So before I get into the details of this new work let's start with definitions. As noted here, LTSS, as defined by CMS is used to describe a variety of services provided to individuals with physical, cognitive and/or mental impairments who never acquired or have lost the ability to function independently. Examples of LTSS programs include those listed here such as activities of daily living, adult day care, social services, etcetera. Next slide.

Recently there's been a shift in focus of care and service delivery to where individuals want and need it most which is in their homes. The Affordable Care Act has introduced a series of incentives, as noted on this slide, that promote the delivery of care within the home and promote the movement of care from institutions such as a hospital or a nursing home, or a skilled nursing facility to the individual's home and community and you'll hear me mention this distinction throughout the presentation institution versus community-based. Next slide.

We must also recognize the value proposition for CMS. One third of Medicaid spending is for long-term services and support and this includes both services provided in the home or the community and within institutions. Next slide.

We must also recognize, oh sorry...building from the previous slide CMS is moving towards community-based delivery models which align with the new financing models introduced in the ACA. We can all appreciate that this shift will be incremental.

As a start CMS has a call to action to standardize how data is collected and shared for LTSS. Standardization of LTSS data is limited due to variances of how the data is collected at the program level and across populations, variances in how data is defined in state requirements, assessment instruments and tools and how it's defined in staff reported data. There are also limitations in availability of quality measures for LTSS. CMS recognizes the systems and procedures used for medical, behavioral and LTSS services are silo'd and non-integrated. Next slide.

So, this brings us to the CMS test program also called the Testing Experience and Functional Tools in Medicaid Community-based LTSS Planning and Demonstration Grant. So there's lots of words we'll just keep it to TEFT. It was introduced in the ACA as a requirement for HHS to identify and publish a voluntary core set of adult quality measures for adults eligible for Medicaid, hence CMS established the TEFT funding opportunity announcement in 2013 and subsequently awarded Medicaid grants to nine states in March of this year and those States are Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, Minnesota and New Hampshire. Next slide.

So, as part of the TEFT program states were encouraged to apply for one or more of the four components listed here. The one specific to the S&I Framework is component number four which is the identification evaluation and harmonization of an eLTSS standard. Next slide.

So, as noted on this slide those states that selected component four are required to participate in the ONC S&I eLTSS initiative. These states must also test and validate the standardize with selected providers and beneficiaries.

States that selected the PHR component of the grant, which is component number three, are also required to participate in the eLTSS initiative, however the S&I Framework does not oversee component number three, the PHR piece. Next slide.

So, now we're ready to get down...so to the details of this work, even though the eLTSS initiative is driven by the requirements of the CMS TEFT Demonstration Grant it will be managed under the S&I Framework process as an open collaborative and public-facing initiative.

The scope of this work is twofold. The initiative will identify, evaluate and harmonize Health IT standards for key client assessment domains and associated data elements to include in an eLTSS plan and the creation of a structured longitudinal person-centered eLTSS plan that can be exchanged electronically across and between community-based information systems, clinical care systems and personal health record systems.

As I stated in the previous slides LTSS data cannot currently be used for quality measurement and quality improvement due to the variance and the collection of the data. By harmonizing across domains and data elements we can get to the granular data needed for exchange, decision-support and reporting.

The administration of community living has also given us guidance on a person-centered planning. We have included this guidance in the orange box displayed on the screen here in the effort to define what the eLTSS plan will be. And if we could just move to the next slide there is a broader definition.

So, the ACL guidance builds on the definition for a person-centered plan as defined under the CMS Medicaid final rule for coverage of the optimal state plan benefit to furnish home and community-based services and draw federal matching funds.

As you read through specific requirements on here, listed here it is evident that the individual or beneficiary is at the center of the services delivered and his or her preferences are what direct what is ultimately included in the plan. Next slide.

So here we highlight some of the key challenges we face with this new initiative. I spoke previously about the limitations regarding the lack of uniformity in the data captured across settings. These points here also highlight that there is a lack of financial incentives in place for providers to coordinate LTSS across provider groups and exchange LTSS information electronically.

We also recognize the electronic LTSS plan is a relatively new concept and there is no consensus on what information should be included in the plan even though the plan itself may contain a combination of clinical care client assessment and service plan data. Next slide.

Even with all these challenges the opportunities are equally important. As I mentioned earlier there is a significant opportunity for this work to build on existing investments made as part of other incentive programs. For, example several states have already developed or are in the process of implementing LTSS information systems as part of the ACA balancing incentive program.

We can also continue to build on the growing HIE infrastructure established under HITECH. The eLTSS initiative also serves to demonstrate that for the first time how LTSS providers that are not Meaningful Use providers as we know them and beneficiaries can benefit from the use of Health IT. Next slide.

So, let's circle back on value propositions for person-centered eLTSS planning. Here we highlight a few examples for how an eLTSS plan can improve efficiencies and promote collaboration across provider groups and beneficiaries.

I'm not going to spend too much time here I just want to highlight that for the eLTSS plan to be adopted across provider groups and by beneficiaries there needs to be a strong business case for both the sender and the receiver of the information and I'm sure all of you have heard that previously so we need to make that case for the value proposition of this work. Next slide.

The standards will identify through the eLTSS initiative, will support interoperable exchange across various information systems to include community-based information systems, clinical information systems or ones, otherwise, as an example EHRs, state Medicaid systems or other payer systems, health information exchange systems and of course personal health record systems.

The contents of this plan will be specific to the types of services rendered and information collected for community-based long-term services and support. And information collected may contain relevant clinical data needed to support the continuum of beneficiary care support and services. Next slide.

So to better define what this will look like we're going to take a step back and understand where we are today and this slide is meant to illustrate the silos that are in place for both service delivery and care delivery.

On the left-hand side we see the existing information exchange between beneficiaries, their caregivers and the service providers. The services are delivered either in the beneficiary home or community-based setting.

On the far right we have the institutional setting silo that encompasses an array of care services to include acute and post-acute care and by that we include hospitals or primary care settings, nursing homes, skilled nursing facilities.

The challenge here is that within each of these silos there are different workflows and different priorities assigned to a beneficiary's needs. The information exchange between these two silos is fragmented and inconsistent. We see a dotted line here because the information can flow in multiple ways either by paper, fax, phone.

Lastly, information about care and services is sent to the payer in different forms using different terminologies and vocabulary. Next slide.

Here I want to illustrate what the future may look like. The To-Be workflow will gradually move us from a patient-centered planning model to a more person-centered planning and information exchange model. Since we're at the start of this work we cannot defer what the technical information mechanisms will be nor how information will flow from one system to another.

What's in scope is the ability for the various IT systems to be able to update and display the eLTSS plan and share data within the plan with other systems. To better understand what this will look like let's consider the scenario where a beneficiary is receiving community-based services in their home as well as treatment in a primary care office. Next slide or click.

All right, so I'll go through this quickly. In this scenario the care team member notes that the beneficiary has missed several appointments, so we're in the red circle number one, the care team member using their clinical IT system searches for information related to the beneficiary's services. The care team member may have access to the beneficiary's eLTSS plan or components of the plan. Upon review the care team member notes that the beneficiary is not currently receiving transportation services and the beneficiary does not have a reliable source for transportation.

Through the clinical IT system the care team member makes a request for the beneficiary to be assessed for transport services so the beneficiary can better meet his or her appointments with the care team.

Number two...here at number two, the service team member receives this request through their IT system and begins the assessment process. The beneficiary's eLTSS plan is updated accordingly and made available to the beneficiary and his or her caregiver so this is number three.

Lastly, updated information regarding additional services provided to the beneficiary is sent to the payer system for processing payment and evaluation. Next slide.

So, what are we going to get out of this initiative? So the expected deliverables for this work align with the outputs associated with all S&I Framework initiatives, so we expect to have a use case, implementation guidance, which is then used for testing and evaluation, and ultimately presented to a standard development organization for balloting and publication. And finally, the recognition of a national standard that can be referenced in future guidance and/or regulation as appropriate.

We also hope to establish a definition for a person-centered eLTSS plan and identify those key client assessment domains and associated data elements to include in an eLTSS plan. Next slide.

So, for those of you not familiar with the various phases, I'm sure most of you are, involved in the S&I Framework process we've illustrated them here in big blue rectangles. The eLTSS initiative will follow these phases over the course of the initiative which is expected to run through the end of 2017.

And as noted this initiative kicked off less than two weeks ago on November 6th. Unlike other S&I initiatives the eLTSS initiative has an established timeline dictated by the timeline of the CMS test program, however, most of the deliverables or work of the initiative will occur over the course of the coming year, meaning in 2015, with the remaining two years strictly focused on piloting, testing and evaluation of the identified standards. Next slide.

And just in case the previous slide was not clear on deliverables and milestones we include more information here. I do want to highlight the pilot phase of this initiative which is noted with the orange stars on the graph.

The first phase of piloting is estimated to start by fall of next year and can run from 6-12 months. Feedback from these pilots will then inform updates to the implementation guide. We'll then have a revised implementation guide that will be tested and piloted again and that becomes part of phase 2 of the pilot cycle.

The revised implementation guide will also be the document presented to a standard development organization for recognition and accreditation. And at this time we do not know which of the SDOs we will target for this initiative but that's one of the questions we have for the HIT Standards Committee today. Next slide.

And you've heard us say several times and Dr. Doug Fridsma used to say this previously, we're not here to reinvent the wheel. All initiatives we kick off are really looking at what exists out in the market and what relevant efforts we need to consider for this work.

So this slide is just a list of some of the relevant projects and it will continue to grow as we move and we have more stakeholder participation and that concludes my presentation. Open for Q&A. Next slide is just who we are.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, well thanks so very much and so Michelle do we have raised hands?

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

David McCallie.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Go ahead, David.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, can you hear me?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

We can hear you.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Good, well, thanks for, you know, a really thoughtful presentation, well organized and clear and I apologize that I don't know as much about this space as I should but I would just throw out some, you know, very naïve thoughts here, one is that this could be incredibly complex to implement and to standardize.

I mean there's just a ton of really sophisticated data flows that you described here and I worry about the burden on the developer community, the vendor community and, you know, perhaps more so on the burden on the provider community to integrate all this into workflows and figure out how to do it all because it looks like an awful lot and I'm wondering if there is a different kind of approach.

I'm looking at your slide number 17 where you essentially have everything flowing through some kind of health information exchange and doing some really sophisticated stuff far beyond what most health information exchanges are capable of doing today.

And I'm thinking that maybe this is...I wonder if this is a case where a really radically different approach might work where the payer system that is managing the deliverables posts an App, a smart App that plugs into these various domains the clinical systems, the community care setting teams and potentially into PHR Apps in the hands of the beneficiary and caregivers so that we don't have to move information around we just put the App in front of them and then the App uses simple services like FHIR to communicate into whatever local needs there are.

So, you could have the payer system expose an App that has the assessment forms required to be completed, they would be filled out by a query into the EHR to pull up appropriate data so that you wouldn't have to ask any questions that could easily be answered with the FHIR query into the EHR then the App would display the deliverable services to the service team, the payer obviously knows about it because they're posting the App and so forth and so on.

I just want to put on the table the notion that I don't think doing this through health information exchange is necessarily going to be the right way to do it. I'll stop there.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

No, David, you're on point, absolutely. This is meant to be a conceptual model and we're looking at...that's what we want innovative solutions like that, what is the best way to do this. We know there is a vision for this work, we know we want to exchange and enable access to the information and so we're looking at these new technologies, absolutely and I'm thinking smart on FHIR would be very applicable for this. And so we definitely want to hear more about this, what your thoughts of what this will look like.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Okay, that's good to hear. I appreciate that. I'm not quite sure how to engage and it's more a function of time than willingness but maybe we can figure that out off-line and maybe there are some others who could help make sure you understand that approach.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Absolutely.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

You know these S&I things can take a calendar and fill it up in a hurry and mine is already full.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

No, and the good thing is we just started. So we're really open for industry to come forth and say, you know, we're doing this or this is how we feel this is going to work and we do...we don't want to create additional burden on the providers, service providers and the vendors themselves. So it's a good time to engage in. We definitely...we'll work with you off-line.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Okay, thanks.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And, David, to exactly that point what I've tried to do for ACO operations is not create an EHR that does all those kinds of stuff but create modules on top of the EHR that provide value added services to non-physician extenders. So the care management medical record uses standards like C-CDA to get data from EHRs and PHRs and then provides, exactly as you've said, in effect an App that allows additional value added functions loosely coupled to existent technology.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I mean, you know, you could say that the App does all the hard work and the connectivity to the local system is through simple agreed-upon data elements. And then you can have a rapidly evolving space of sophisticated management of all these workflow items to communicate the delivery of the care services and you needn't bother with moving all that around amongst all these EHRs who fundamentally aren't interested in that.

So this seems to be a prime candidate for injecting a user experience into the workflow of the physician to capture whatever is missing but otherwise keep it way away because it's not going to add...it's going to add complexity without a lot of value that will be just harder to do, harder to build. Anyway, yeah, I agree.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, very wise guidance. So, I think, Evelyn you've heard that loosely coupled leverage standards not to build this into an EHR but more an App or a standalone vehicle used potentially by a different population than would be using the EHR.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Absolutely, yes, and we definitely want to go that way. We've never thought of being...building this into the EHR. We've heard from vendors that that's not what you know...we want to make the information usable for who needs it at the point of service.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Michelle do we have other folks in queue?

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

Yes, Dixie Baker.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Dixie, please go ahead.

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

Dixie if you're speaking you're muted.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Dixie, are you muted?

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Yes, I just...I had unmuted but didn't press the button hard enough, okay, I'm here. Thank you, Evelyn, thank you for bringing the needs of this segment to our attention we hadn't heard of it before.

As I listened to you it seemed to me that the needs and the challenges that you were describing were very similar to those that John Derr often points out to us with respect to individuals receiving long-term and post-acute care.

I think there is already an S&I Framework initiative that addresses long-term post-acute care and I was wondering first of all maybe there are important differences that I'm missing but if not couldn't these communities possibly join forces to address some of these common challenges maybe even through the approach such as the one that David just described?

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Absolutely, Dixie, I'll just clarify that this work is an offshoot so it builds off the initiative you were mentioning is the longitudinal coordination of care and we just closed so that initiative ended in September and the community was invited to participate in the initiative. So it is the same community and they're also contributing what they provided to the LCC community so we're not, again, not reinventing the wheel we're building on the work we've already done.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Oh, okay, I didn't...I somehow missed that, sorry.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, thank you. Michelle, anybody else?

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

Leslie Kelly Hall and then Floyd Eisenberg.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, Leslie go ahead.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thanks, building on that theme, making sure that when we look at new technology might help this problem we also learn from other efforts, as Dixie already mentioned, the work in the long-term care, we also had work done in the patient generated health data under the Consolidated CDA where we defined the patients and all their care team members in a very thoughtful way using CDISC as our guide, so some of those more thorny issues and details regardless of what technology might be used as a solution can help inform and guide this, because we want to make sure that the patient isn't at the center but actually in the ring. So they are participating as equal members and we can learn from some of these efforts. So, making sure we don't throw out the good efforts that have already started and that we build the patients in this model as an equal.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, well said and thanks, just as John Derr always reminds us of the importance of LTPAC thanks for reminding us about keeping the patient in our focus. So, Floyd Eisenberg?

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

Yes, thank you very much. So, I want to build on the last three comments. First of all the idea of an App and if you go back to that drawing that you presented rather than the health information exchange and I have some very recent personal experience having addressed a transfer of care from an observation unit back to a long-term care facility just this morning and an App would have made things a whole lot easier for coordinating between multiple individuals and I think it's very important that you have caregiver and beneficiary so I support the patient or patient extender as well.

My question is really about the quote "small" data set that needs to be managed by may be more than one provider because some may come from a therapist, some a physician, some other providers where does that come from? Who defines that?

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

So that's one of our deliverable slides so we have to...

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

Okay, I'm sorry.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

No, you're asking the right questions, absolutely, we're not there yet, we want to...our scope of work, the first thing is to come up with the domains, key assessment domains and data elements that will be what are included in the eLTSS plan.

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

All right, one thing I would caution, don't just look at post discharge there are situations where people don't get admitted they going to observation and still have the same needs for transition and transfer but they're not hospitalized. So make sure you...I think it would be important to be aware of that it's the same transition planning, the same care planning that needs to occur it's just not a hospitalization.

Evelyn Gallego-Haag, IMBA, MBA, CPHIMS – S&I Initiative Coordinator – Office of the National Coordinator for Health Information Technology

Right, yes, absolutely, yes, thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great, well thanks; I think we are right on time. So, Michelle, if that is the end of the comments I then want to thank Evelyn for the thoughtful presentation.

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

Wait.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes?

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

John Derr has a comment.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Oh, of course, John Derr this is very important for you, go ahead.

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

Yes, I'm very excited about this and I am involved in it. Also we have put out to the community to get on the Wiki and to be on the Thursday calls for this because it is very important and Evelyn, thank you, you did a great job and the whole community of long-term post-acute care and behavioral health is excited about this because as you all know it is very important. Thanks.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, thank you. Well, let us now move on to the standards and technology updates from Steve Posnack who is running our Office of Science and Technology so well and hear about certification updates and FHIR plans and things that ONC is doing to champion the standards cause.

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

All right, thanks a lot everyone. This one is going to be quick so if you are multitasking it's going to go by in the blink of an eye. So, next slide, please.

Today in part the agenda for today is a reflection of some of the feedback that you've already given us relative to areas that you'd like some increased visibility into either S&I Framework activities or other work, you know, Wes being a champion of bilateral asynchronous cutover, I don't know if I'll ever get tired of saying that, and, you know, how we can kind of keep you informed of activities that either we are following up on or that are relevant to keep in your mind based on the work that you'll be asked to do in your Workgroups and other capacities.

So, the one thing update-wise just is the normal appearance here on the agenda, we had put out the 2014 edition release 2 final rule, the test procedures went out for public comment for a period of 30 days, the team is working on revisions in response to those public comments.

And another component to the work toward implementing the 2014 edition release 2 final rule was the addition of a new testing tool for the support of the edge protocol implementation guide with respect to the Direct protocol.

So our colleagues at NIST have implemented a first version of that, the alpha release was completed on 10/30 that's available for public feedback. So for those of you that have asked for earlier versions of testing tools to help kick the tires here is your opportunity. Please give feedback to our colleagues at NIST relative to its performance and other things that seem to need to be addressed and the following is a rough sketch of when our colleagues at NIST and my team feel as if the tests will be ready for a production release. Next slide.

This is the last slide here for the updates. So, I've given a brief presentation before on the CMS designated test EHR pilot program. Again, wanted to thank the two EHR developers that have since withdrawn and concluded their performance under the program for a period of a year that included Meditech and McKesson, and not to not acknowledge, but actually to really thank the folks from iPatientCare who, you know, I would probably have been remiss not to have acknowledged them the first time around, they have stuck it out through and have really been performing excellent in terms of supporting all the providers that have been interested in doing a test and so thank you again to our colleagues at iPatientCare serving in that role in a continued capacity.

And then we want to welcome, thanks to David McCallie and his fine folks that the Cerner Group is going to be joining as a test EHR pilot type of...sorry a CMS designated test EHR program participant and we very much thank them for their ability to engage their resources to work on this effort.

The one thing to mention which will be I think brought forward through some of the work being done I believe the Implementation, Testing and Certification Workgroup, we had this pilot over the past...over the summer through the early fall months relative to open test method development and so there will be some feedback and some lessons learned presented to that Workgroup.

And then there is another slide attached which is really just a synopsis related to all of the...as everyone likes to do things on FHIR, the ONC on FHIR slide which I think for those of you that aware of or familiar with some of the S&I Framework activities that are also engaged with FHIR work there's a copy of that slide, it's really more so for your reference in terms of the detail not to be I-Chart depending on what type of display you've going on just to give folks overall context in terms of the four activities of which we're engaged in.

So that's a rough rundown of some of the updates. I know that we've got, next after me, Johnathan Coleman who is going to be doing a circle back through on the data provenance S&I initiative again another opportunity to provide the Standards Committee with the opportunity to provide input and direction, and general feedback in terms of the strategic impact that these initiatives can have and we're at an important time in the data provenance's lifecycle through S&I where your feedback relative to the use case will be very much appreciated and important for its ongoing work going forward.

So, that's it for me on the ONC updates. I am going to talk again on another matter after Jonathan does his presentation, so thank you very much for your time.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, Steve thanks for that update, that was very fast and information dense. Now, as a keeper of the S&I Framework I think one of the fascinating challenges that you'll have over the course of the next many months is making sure that we focus on those initiatives that are going to have the highest impact.

And when we think of FHIR and the potential for enabling discrete data element retrieval with a common Meaningful Use data set of scope and document retrieval, and simple transport using REST, and the security enforced by OAuth, you know, that's one of those very high value going to be adopted very widely, impact quite a lot of people type of initiatives.

And so, just as a general question for you, knowing that there have been many SI& initiatives is there a process at ONC to sort of re-examine which initiatives are in process, which, given limited time and resources are of highest value and to try to trim back to the smallest number that we can actually achieve given that we all have finite bandwidth?

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

That's an information dense question, John, but certainly appreciate it. We are going through, and I'm leading that review, to look at the S&I initiatives, you know, some of them that are listed as active have really made their way into the either pilot or completed pilot and valuation stage and we can, for clarity, you know, kind of phase them into a different mode or recognition relative to their existence in the S&I Framework and I think as we go through that process we'll be able to more clearly identify those initiatives that are I think in large part collaborations between ONC and other agencies, and the community that we feel folks, you know, per David McCallie's conversation with limited bandwidth on everyone's calendars, those that will be the most impactful for varied participation.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very good because as I look forward to the work in the next six months or so what I recognize is the human brain can focus on three things at once and so...or maybe five if you're really talented and so hence I look forward to that review to say, you know, as a Standards Committee, and of course you're going to reflect as to our Workgroup organization shortly, how can we ensure that we are hitting those deliverables that are going to have the greatest impact on the community. But Michelle, are there other people in queue?

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

David McCallie.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

David, go ahead.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, Steve, this is probably too detailed for this conversation and maybe I will just queue it up for discussion at some point, but when you mentioned the edge protocol I realized I haven't tracked the details of the Direct edge protocol nearly as closely as I probably should have, mainly because I've exceeded my limit of three simultaneous thoughts in my head as per John's assessment, but I've gotten some feedback from our team that the edge protocol is too limiting if the only thing you can do is move an XDR message that, you know, we're starting to see Direct being used for quite a number of other things besides just moving CDA documents around. Is that something that's being discussed and is that...is there an approach that lets some more generic message be passed or am I completely confused?

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

We may want to take that off-line David so I can kind of unpack either the concerns that have been expressed to you and whether they're part of what we've got going on for the test tool. So feel free to reach out to me and I can link you up with the right folks.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Okay, thanks.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Michelle, any other folks?

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

Sorry, no one else is in the queue.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, well thanks very much Steve and you're right on time as we move forward to the provenance use case with Julie and Jonathan. And remember that as we prioritized our work a few meetings ago we thought that data provenance was actually one of the most important initiatives over the next year and so these folks are going to outline for us the use cases and the scope of how we should think about provenance work going forward. So, Julie and Jonathan turn it over to you.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Great, thank you, John. This is Julie Chua and is Jonathan on the line?

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

Yes, good afternoon, Julie and everybody I'm here.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Great, so on behalf of the data provenance initiative community and the support team we do want to thank the Standards Committee for this opportunity to present our use case and we also, as you know, we would like to obtain your feedback today as we go forward with our phases in this initiative. So I'm not on on-line, Michelle, so I'm going to go over the agenda real quick.

And basically we're going to go through the initiative purpose and goals just to refresh the committee on what we're doing within this initiative and I'll go over the initiative progress to date. We will show you a slide of all the candidate standards that we have so far identified with the community, and that is a work in progress, and then Jonathan will take over and go over the use case summary for the data provenance initiative, and then you'll see on this slide some of the questions that we will be asking you at the end of the presentation and a more detailed slide will have more of the details of what we would like to get in terms of guidance from the committee.

And basically what we are trying to get from you all is, one did the community actually miss something that's potentially is more impactful, where in the use case should we start in terms of evaluating standards to meet use case requirements, and the third question would be are there any architecture or technology specific issues for the community to consider. So, next slide, please.

On this slide I just want to go over again the purpose and goals of this initiative and it is basically to establish a standardized way to capture, retain and exchange provenance of health information. And within the community we have set ourselves up to define an initial set of provenance metadata and vocabulary and we are also trying to create technical specifications for standardizing data provenance as creation during exchange and when that data is actually integrated across multiple health information systems.

And another goal that we have within the initiative is to develop guidance for handling that provenance data in content standards including the level of granularity with which provenance should be applied. Next slide.

So, to date the initiative progress are as follows, we achieved consensus on the charter in June and then we achieved consensus on this use case that we are presenting to you today mid-October of this year. We have also been participating in the HL7 implementation guide for the CDA R2 for data provenance for the September ballot.

And the next slide is going to show you some identified candidate standards that are being considered within the harmonization phase of the initiative. And basically with the most recent community calls we have actually identified SMEs for specific standards who could present to the community and give them a better contact and a better handle on how these candidate standards will apply to the data provenance metadata standards and implementation guides that we will be putting together. So, next slide.

As you can see it's a long list and these are some of the candidate standards that we have identified and this is a work in progress and I'm not going to go over each bullet but just to give you an idea of the standards is that we are looking at and the extensive list that we are looking at for this initiative. Any questions so far before I hand it over to Jonathan?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Michelle, anybody in queue yet? It doesn't sound like there are any questions.

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

Sorry, there is, Leslie Kelly Hall.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes, Leslie?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Hi, thank you. I wanted to make sure that you were coordinating this with the Consolidated CDA patient generated health data template header so that patients were included and all of their designees and also one notion that was talked about early on was a, not only provenance issue, but the ability to have a tamperproof field when information was passed from another party other than the author which will very much happen as patients start to view, download and transmit their data to parties. We want to make sure that the data and provenance is retained and there is some sort of field that allows the patient to act as an exchange, a health exchange of one. So, can you comment on those?

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Great, thanks Leslie and actually those are great points to point out and as you all will see with the use case summary that we are going to go over or Jonathan's going to go over, you will see that there are places where we do identify provenance events and where different actors are at the start point or different actors are going through the workflow of the provenance information exchange. So, I think your question or your point will be addressed in the next few slides.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Okay.

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

David McCallie and Floyd Eisenberg have questions.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes, David?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I probably should save my comment until I hear Jonathan's comment and understand the use cases better, but I look at this list of candidate standards and it's a bewildering array of heterogeneity and complexity and I'm just thinking that in the private industry outside of healthcare they would never do something so complicated for something so fairly fundamental and I'm just hoping we aren't just terrifically over complicating this process.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

That's a good point David and as I said, these are just standards that were put forth by the community to consider. I don't believe that we would try to even make sure that we use all of these standards but we are trying to make sure that we do consider all of the ones that are relevant and parse it through and work with the community to see which ones are appropriate to move forward with.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Good, simplicity that's all.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Yes, yes, absolutely.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Or parsimony, you might even use that word. I'm sorry, and Michelle, did you say Floyd had a comment?

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

He did.

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

Yes, this is Floyd.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Go ahead Floyd.

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

So at the risk of...well I agree completely with David's comment about the number of standards you're looking at here and at the risk of causing an issue with that there's one standard that you're not listing here and that's a NIST review for usability 7804 is the name of the document number and it addresses provenance in the sense of providing to users that the right information and the history for specific information is presented together so it's available to help you understand it. And not to add to complexity but I do think it's something that usability should be considered as you're looking at provenance.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Great, thank you Floyd, I did make a note of that and Jonathan you should make sure to present that to the community as well and include it with the list.

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

Yes, certainly will do, thanks Julie and if I could just comment briefly on the process here for evaluating these standards. As Julie mentioned we are in the process or have identified individuals within the community who are knowledgeable with each of these candidate standards and our goal is to put on a mini concert series or our process is to put on a mini presentation 10 to 15 minutes on some of these standards and allow us to, as a community, better understand what the standards are good at, where their focus is and how they apply to the use case.

And it's our expectation that this simple exercise will allow us to determine whether or not these standards are in fact attributable potentially to this use case or if in fact they were...they sounded good at the time but might not be as useful as we originally thought. So there will be a reduction in the number of standards that get further analyzed and really more objectively scrutinized in terms of specific use case requirements.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Hello this is Eric Rose, John; again I don't mean to jump the queue but is it appropriate to jump in with a question here?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Of course, please go ahead.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Thanks, actually there were two and I don't have...I'm not looking at the slides now but I did review the deck, there were two things that struck me, one is I don't recall seeing an itemized list of the data elements what are the critical data elements for provenance and I think that this would be useful to consider because that could then guide what standards would suit or not.

And the second that would be a useful way to I think to derive the data elements is user stories, who cares about provenance, who is going to look at provenance data and what conclusions are they going to make from it, and the two that I'm aware of is the physician or the clinician responsible for care of the patient looking at historical data may want to look at this data for two reasons, one to determine the date at which a piece of data entered the system, so if a diagnosis of a malignancy was entered but subsequently was ruled out with a, you know, appropriate diagnostic study that's really...that really is important.

And the second is determining or making a judgment about the veracity of a clinical judgment, you know, if I see that schizophrenia is on a patient's problem list but then that this diagnosis was made based on a visit to an urgent care center from a clinician whose saw the patient once that this would help me as a clinician make a judgment about the veracity of that data.

So, I think including those kinds of user stories will help you determine what's the minimum amount of data that you need, you know, do need to know the name and demographics of the end user who entered a piece of data or their professional designation or the care setting, etcetera, etcetera, at least and I think those need to be itemized.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Yes, thank you, Eric. This is Julie again and you hit it right on target, the use case document itself does have those data elements that the community has put forth as well as user stories to clearly identify and clearly relay what this use case is trying to scope in.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Okay, I may have missed that, was that separate from the PowerPoint deck?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So it's coming, that is Jonathan's piece.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Yes.

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

Right, so thank you so much, can I take that as a segue?

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Indeed, please go right ahead.

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

All righty, thank you so much, all right, so I've just got two slides before we get into asking the committee members to respond to some specific questions to help guide us in our focus moving forward because as we've heard data provenance means so much to so many and we feel like we've got a little bit of a, you know, boiling the ocean task ahead of us and what we'd like to do is slice our use case up into manageable chunks and, you know, still take on each chunk but maybe get some guidance as to which chunk to take on first and just to loop back around to Eric specifically, there is a broader use case document which is fairly lengthy and does have a starter list of data elements in it but it's our expectation that as we develop the implementation guide we'll get further refinement on those data elements.

There is also now a two-page executive summary document which highlights some key areas of the use case and hopefully they've been provided to participants on this call. So, I'm going to summarize in two slides three bullet points on this slide and then a diagram. Our main scenario is going to encompass a number of different user stories.

So scenario one is the most simple it describes a simple provenance event in terms of transferring healthcare data from a start point which would be the sending system to an endpoint which is the receiving system. And again trying to keep this simple we are assuming that there no intermediaries or no changes made to the data along the way and this literally gets to the point of when we create healthcare data or health information what are the provenance attributes that should be generated and captured, and transferred along with that information as its exchange however that ends up being exchanged.

Scenario two gets into a little bit more detail in terms of asking the question what happens along the way. So, in scenario two we have a third-party which is used as a pure conduit or transmitter to transfer information from the start point to the endpoint this could be synchronous it could potentially be store and forward but we understand there are use cases where it's important to know how the information was routed as well as who originated it and who indeed sent it.

And then thirdly, we start to add even more complexity here where we have the start point where the information is either generated or already exists and it uses a third-party system to aggregate or combine information from multiple sources either in whole or in part to produce brand-new healthcare artifacts based on new information or previously existing information, or some combination thereof.

And this has got the notion in some cases that this may be done automatically through some kind of algorithm such as give me everything you have on this patient and create something new from it or that there may be some human logic involved that says, you know, I want to include this piece of data and that piece of data and create a new healthcare artifact with just those pieces.

So we've heard user stories that fit into all of these different scenarios and if we move onto the next slide we've tried to capture that in the form of a UML diagram. I'm going to very briefly talk through this UML diagram but please understand this is a work in progress, the community is working on this through our meetings and we are overlaying this diagram with provenance specific events as well system specific events that are notable but not necessarily on the critical path for creating provenance data.

So the first swim lane is the initiating system, the second, third and fourth swim lanes, the middle swim lanes are the transmitter, assembler and composer, and then on the far right-hand side we have the receiving system.

So, if we start with the initiating system there are a number of system events that could occur before a decision is made to route the information to the receiving system via the transmitter, the assembler or the composer and they all include a trigger event by the initiating system which could be an electronic health record system, a PHR, a lab or a patient generated device and in each case there is some trigger event and clinical data is created and there is provenance metadata associated with that generation of clinical data.

Presumably, the device or the system that created that information will maintain it and persist it somehow and because of our user stories and our scenarios we want to share that information so an exchange artifact is created and it is either attested to or asserted in some way that this is the information to be exchanged and then it is either sent to a transmitter, sent to an assembler or sent to a composer, or sent directly to the receiving system.

And along the way if we just take assembler as a good example, which is the third diamond decision point in the initiating system swim lane, the assembler would receive the clinical information and the provenance metadata. In this case the assembler would access that clinical information, extract and aggregate the clinical data, maintain it and then create a new exchange artifact which would be sent on to the receiving system. So that's one example of how an assembler could be combining information from multiple sources and sending it onto a receiving system.

Similarly, the composer as it receives clinical information, it would need to access clinical data that it may have in its own repository extract, select and consolidate clinical data so this is the cherry picking step and then again creating a new exchange artifact and sending it on.

So the questions associated with this are, you know, there are so many and we've tried to capture as many of the provenance related events in this fairly complex sequence as we can. And our intent is to focus on how that provenance metadata should be conveyed, what structure, what format and at which points in the sequence here should actually be provenance events defined and what form should they take.

So, I know this is a very speedy, high-level view of a diagram which somewhat summarizes the use case and is being tweaked and updated as we continue to work and build out an implementation guide but you can see that there are system events that happen inside an EHR system or intermediary such as a health information exchange. There are system events or events that happen with the initiating system which could be a patient generated device or PHR, or another EHR and similarly at the receiving system there are also provenance related events that could occur.

So we are trying to tie it all together and as we evaluate that long list of candidate standards we'll do it with system events or information interchange events in mind.

So with that let's move on please to the three questions which are now on three separate slides and we have...we don't necessarily have to do this in a multiple-choice way but we've put some suggestions to maybe help facilitate a conversation understanding that we want to leave time for questions and answers as well at the end. So Julie, should I hand over to you at this point for the questions?

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

Sure, and if we can go through that slide with the first question please.

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

Yes, it's up Julie.

Julie Anne Chua, PMP, CAP, CISSP – Information Security Specialist – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Department of Health and Human Services

It's up, okay. So, the first question is, do the three scenarios in the use case and the use cases identified scope address key data provenance areas or is something missing? And this is something that I'm envisioning an open discussion at this point John with the committee.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, and I wonder, just as of matter of process, as we go through this it may be Steve Posnack that our Workgroups, as you will talk about their formation, should actually dive through these because these are all heady questions.

I was asked today by a payer, so does the doctor at Beth Israel Deaconess sign the CCD or C-CDA and of course I'm not even sure what it means today to sign a C-CDA, you know, and so as you have sort of illustrated here there are some interesting questions that we will have to puzzle through probably in our Workgroups as to what it means to assign provenance to a package and is it a digital signature that is simply validated along a trail or is it something more? But, hey Jacob welcome your comments on that.

Jacob Reider, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

So, John I think that the right process for those kinds of questions is Workgroups or these work teams that Steve has described today because I...and then I think the work team's Workgroups would then bring the results of those conversations, those deep dives, because we could chase our tails on these conversations for many Standards Committee meetings. I think that's the perfect place for the work team's Workgroups would be the right place for us to have these conversations in depth and then bring forward the recommendations to the full committee.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, that sounds good. So maybe you know the thing to do at this point is to just go ahead and if you would Julie just go and through the questions so we can tee them up but then we'll hear from Steve as to a Workgroup organization and think about how to assign those questions to our Workgroups.

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yes, this is Steve, if I could just chime in a little bit in terms of, I guess maybe process and timing, so, I think what we'd like to avoid as part of this conversation is putting this initiative work on hold because it is ongoing and so I think if there are efforts that are relevant in parallel for the Standards Committee to look at and respond to ONC requests for advice that this can certainly be worked on but, you know, I think maybe we should...we could be clearer about this or at least up front right now process-wise.

This is an opportunity...we've brought the team forward to provide everyone with an opportunity to weigh in on the direction of the data provenance work and the trajectory of the inquiry that they're going down is these use cases that they've put together when they go ahead and do the work and dig deeper into this would generate impactful results for the community. I think it may be, you know, potentially duplicative if there were Standards Committee groups that would also focus on these issues.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very, well, I think that there are valid Workgroup comments such as, gee, you know, your use cases are very interesting and whether there is a sender, a receiver, an intermediary or an assembler really all you need to do is validate the digital signature at the resource level and the flow is immaterial. The assembled data would be validated, you know, at the resource level by the receiver or something of that nature.

And so I certainly am all for moving quickly but I wonder if we might get Workgroup input that might radically simplify what you have suggested as use cases. But, hey open it up to others who might have comment on that.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, it's David.

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

...

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Please, David, go ahead.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yeah, I'm with you. I mean I think this question one you need a choice number C which is your scenarios are too complicated. Focus on the simplest use case of being able to verify the digital signature of a, I'll say a resource and I'm thinking granularity like a FHIR resource, and that resource is signed in some way once it leaves the boundary of the producing institution and it can be validated by a receiver no matter what the path that it took that it was in fact unchanged since it left the sending institution. That's hard enough.

The thought that you could actually track where it flows and how it got there and whose looked at and how many minutes they looked at and whether they actually understood what they read when they read it or whether they agreed with it or disagreed with it those are all issues for the NSA but not for us.

This seems really, really complicated for, you know, a process that works pretty well in other industries to validate the digital signature of a PDF or the NV5 signature of a downloaded executable, you know, I don't care how that zip file got to me as long as I can verify that it hasn't been tampered with.

So I would argue for keeping it a lot less complicated, reduce the number of scenarios to just number one.

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

Yeah this is Jonathan. I think that maybe question number two helps guide us in that direction. And, you know, part of our challenge David is that we've got members of the community that feel very strongly that, you know, exactly the way that you just declared it and we've got others that are interested in other aspects of the provenance.

So part of our question is, you know, where do we start. So, I think we definitely want to keep it simple but we know we have to divide this up and address it in chunks but which chunk is probably the most impactful first might be another way to put this question.

Or, I don't know Julie, maybe if jump to question two that maybe might guide us there as well. Where would the committee if there's an obvious answer, where would the committee like to see us focus initially and if there's no obvious answer then that's good information too and we'll work that out with the community and the Workgroups.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

I just think we have to be cautious of you know the tyranny of the edge case, you know, there will be more demand than we can reasonably meet so you really have to find a way to prioritize to the absolute core, learn from that and then if there are gaps after learning from solving for the core problem come back and address them. But, yeah, I mean this could get overwhelmingly complex and very few would benefit from it.

Johnathan Coleman, CISSP, CISM, CBRM, CRIS - Initiative Coordinator, Data Segmentation for Privacy Principal – Security Risk Solutions, Inc.

Agreed, thank you so much.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes, Eric, please go ahead Eric.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

I was going to echo what David said and I think again you have to tie it to what is the human use case that you're trying to support and I think really what provenance supports is knowing when to doubt or when to trust more versus trust less data that you're looking at and I think if you focus on that I think a lot of the questions will be answered.

The other thing that occurs to me is that you can't transmit data that hasn't been captured and the capture of this data really I think overlaps a lot with audit functionality of electronic health record systems at least auditing of entry and editing of data. And I actually don't recall exactly what's in the certification standards currently for that but I think that those need to be considered very much together the what if anything being required for auditing data entry and provenance and I think the one is required for the other.

Wes Rishel – Independent Consultant

This is Wes.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes, Wes, please go ahead.

Wes Rishel – Independent Consultant

I think that the comment from the speakers about implying a great deal of controversy about the scope of this effort in their committee reflects well on the committee in the sense that this is a big deal.

Depending on how it gets scoped out the impact on certified Health IT to restructure how they maintain data could be enormous and therefore in the scoping decisions, that are always a trade-off between perceived benefit and perceived complexity, it's really important to find ways to validate the value versus complexity trade-off.

So if I were speaking for the Standards Committee and I perceived the request for advice from this Workgroup...hello? Hello?

Multiple voices

Is anybody else hearing noise on the line?

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

Yes.

Wes Rishel – Independent Consultant

Okay.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

If you could mute if you are on.

Wes Rishel – Independent Consultant

I should be able to shout louder. The advice that you're hearing from the committee is err on the side of reduced scope in favor of getting faster to a trial implementation. I mean nobody...nothing in technology gets done right the first time. And attempts to do it right the first time have led to massively doing it wrong.

And I'm very concerned, in fact I was originally going to ask what was the composition of the regular attenders of this Workgroup for fear that it wasn't balanced that it was tipped towards those that perceive the advantages of a broad...of a detailed implementation. Based on what you've implied about the controversy I feel a little more confident but I think we really are, as speakers here, representing our concern that this is not an area to go overboard and defining...you know it's overboard on a small boat.

I would say that the use is a separate question, the use cases that were listed to the...at least the ones that are implied by the rows in the swim lanes are kind of highly technological. They represent very abstract differences in process for users but they don't provide any benefit in terms of analyzing the value for the value versus cost trade-off and so the question that you asked, do they address key provenance areas "yes" but are they the right questions I'm not so sure about that. Thanks.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So Wes, you know, what I see is the S&I Framework is...has many masters, right, the Standards Committee as a Federal Advisory Committee and so we provide some elements of scope, but ONC has many federal agencies that are asking for additional scope, oh, the PCAST Report asked for additional scope and so, hey Steve Posnack I feel your pain.

And so maybe the usefulness Wes of our Federal Advisory Committee is that we can suggest despite the clamor of many, many stakeholders for many, many use cases, edge cases and very large scope the best way to succeed is by choosing one use case and doing it simply and proving that it works and learning from that effort.

Wes Rishel – Independent Consultant

I'll second the motion.

Rebecca D. Kush, PhD – Founder, Chief Executive Officer, President & Director – Clinical Data Interchange Standards Consortium (CDISC)

This is Becky and I had my hand up.

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

There are a bunch of people in the queue.

Rebecca D. Kush, PhD – Founder, Chief Executive Officer, President & Director – Clinical Data Interchange Standards Consortium (CDISC)

I'm sorry.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I'm sorry, Michelle, did you say we have many people who want to comment?

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

Yes.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Go ahead, you now run those in order so that we give everybody a chance.

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

Okay, well, Becky, you took your hand down did you still want to speak?

Rebecca D. Kush, PhD – Founder, Chief Executive Officer, President & Director – Clinical Data Interchange Standards Consortium (CDISC)

No, I do want to speak and I had said when I addressed this as a very important area to go into on the HIT Standards Committee a few months ago that there should be a look at 21 Code of Federal Regulations Part 11 because it is the way that the FDA does traceability which I pretty much equate to all this discussion on provenance. It's a federal requirement when you use these systems especially for research but it is quite simple and it goes through how to track who entered the data, what was entered, if there were any changes made, why the changes were made, who made the changes and when. So those are their elements and I think it would be very wise to look at this.

There's another standard, and I hate to add to the list, but it does exactly this and it is the operational data model and it's being used with EHRs in Germany so it has had implementations taking data from EHRs and moving it along. So I strongly recommend reading that 21 CFR Part 11 and looking at the operational data model.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very helpful. Michelle who's next?

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

Anne LeMaistre.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Anne, go ahead.

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer - Ascension Health

So, thanks John, I think you beat me to it I was just going to support David's comments and I think you're right that we need to walk before we run. And that one good use case is what we really need to prioritize and move forward on swiftly.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very good, thank you. Next, Michelle?

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

Floyd Eisenberg.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Floyd?

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

So I'm listening to all this and I agree with the issue of simplifying to an extent but I basically think the happy parsimonious path of thinking of two clinical use cases one is direct clinical care and what a clinician needs to understand about the data to care for the patient and what the veracity of the data might be.

There is also the secondary use for research decision-support and that measurement that addresses care about that patient that includes data from elsewhere and it's a different use case and may need slightly greater provenance concerning any change to the data redacting or adding to, or modifying and that's either going to mean external data can't be used or it can be used.

So I'm not trying to add complexity but I just think we need to be upfront about what we're looking at and if it's available, and I think Becky spoke to some standards that would help there, without adding too much complexity. There might actually be two use cases not just one.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, so, Floyd you and I of course use the word parsimonious a lot so whatever is the fewest number of use cases that will get us to a reasonable scope where we can learn and prove from experience what next steps might be sounds reasonable. So, next, Michelle?

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

Dixie and Leslie and we're running out of time so if we could be as quick as possible.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes, so, Dixie, Leslie and then we need to move onto Steve Posnack.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Okay, thank you Julie and Jonathan. I do agree with a number of the comments that have been made so I won't even articulate exactly whose comments I agree with, but I would say that the approach seems extremely focused on the exchange of provenance data rather than on the value to the clinician which is really what Wes was pointing out.

I agree that the exchange use case or scenario should be very simple but the real focus should be on what clinicians care about which relates back to Eric Rose's early comment about the need for critical data elements and as Becky pointed out there are existing models out there. But to me that should be the focus.

The purpose of data provenance is to help the clinician determine how much the data can be trusted and this is more than just where the data came from which can easily be determined outside the realm of provenance or even who digitally signed it which relates to content attribution again not necessarily provenance.

For example, the clinician would be interested in knowing whether it came from, a simple example, from a mobile App versus an enterprise system or I've heard many clinicians mention they want to know whether the data were generated using natural language processing because they trust it less if it is NLP generated.

I think this whole project needs to be refocused on the data elements and what clinicians care about and the central purpose of provenance which is not just who sent me the data.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very, very helpful and so I think what we've heard is just generally that, Steve, although you would like to move forward in parallel there are many folks who would like to make your job easier in reducing scope and helping you focus.

And so one wonders if you could actually achieve a better outcome faster with a smaller scope and we're certainly happy to provide a Workgroup to help you with that. And Michelle, you said there was one last comment?

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

Leslie Kelly Hall.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Leslie, go ahead.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Hi, I wanted to make sure we're not, as we simplify, solving the same problems that we did with Direct that tells us who sent something from place A to point B which is the minimal transmit, right, did something get sent securely from A to B, but what provenance really gets to is the creation of the source of the data trusted, is it valid and is it something that I can act on.

So if we just simply focus on transport my concern would be that we haven't really resolved the authoring issue and then we have further disintermediated the patient as a direct contributor. So, but I'm not sure where you're going to land Steve I think there is a lot of controversy that still needs to be worked out.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And Leslie to your point, I mean, this is a notion of digital signature so we recognize that encryption technology can both be used to ensure data integrity but also to infer authorship and so I'm sure Dixie would be very helpful in making sure that we would adopt the right digital signature standards to achieve both ends.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I would be happy to help but I don't think digital signature is a provenance mechanism. I think it's a message content attribution mechanism which is different.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, perfect, you see, see how much we can help you with the scope of this? So thanks very much and of course we are but a Federal Advisory Committee and so you have heard the consensus of the advice Steve is that although you want to rush forward a very short pause to re-scope and get our input will probably help you succeed faster. That's our view.

So let us now move on Steve to your final presentation on how the Workgroups can be optimized so that we can actually help you get to that end result faster.

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Sure, thanks a lot and, you know, just maybe since I've got the microphone now, you know, the conversation that just occurred was at the level that at least I had hoped that it would directionally and I'll have to talk with Lucia our new Chief Privacy Officer about her interest in data provenance and circle back with, you know, the rest of the team to see what our next steps are.

It is a community activity in which a number of stakeholders have already invested a lot of time so I think we need to be respectful of their efforts to date as well. But I very much appreciate the comprehensive feedback that folks have provided.

So onward and whoever is running the next in the slides is going to do a coordinated ballet with me here. So, you can do next slide, please.

For the agenda here I will talk a little bit about the Standards Committee Workgroups, the current state and some proposed efficiencies, some questions that we think interdisciplinary advice is warranted, some next steps and then if have a brief time for discussion we can do that as well. Next.

So, as Jacob opened the meeting, you know, one thing to remember and I thought it would be wise to do so, we probably haven't done this since we kicked off the Standards Committee in general, here's the HITECH language that established the Standards Committee and, you know, as statutory language goes "there is established a committee to be known as the HIT Standards Committee to recommend to the National Coordinator standards, implementation, specifications and certification criteria for the electronics exchange and use of health information" and, you know, as Jacob has so eloquently emphasized it didn't just say, you know, for the EHR incentive program, it didn't say for EHRs it's actually pretty broad and in terms of the scope and purpose of the Standards Committee's recommendation. Next slide.

Oh, I guess all of the animation didn't make it into the slides. So, this summer the Standards Committee initiated a revised Workgroup structure. These Workgroups are generally based on the model we've often used in presentations to categorize standards and so you can kind of see the arrows as they move from left to right as we categorize standards as vocabulary and code sets that's been since turned into the Standards Committee Workgroup of the Semantics Workgroup.

As it turns out this approach is a great way to identify disciplines and subject matter experts yet at the same time it can result in Workgroups that may not be equipped to take on the types of interdisciplinary/strategic standards and technology issues on which ONC may seek advice in coming months.

As many of you know, with the exception of the wonderful Julie Chua who just spoke on data provenance who hails from the Office of the Chief Privacy Officer and staffs the Transport and Security Workgroup, all the other Workgroups are staffed by personnel from the Office of Standards and Technology.

For the past couple of months ONC staff have worked with the Co-Chairs of these reconstituted groups to develop work plans. Similarly I've been working with ONC staff and we've identified some challenges that could lead to a high potential for overlap in the need for multi-Workgroup coordination because the scope of the question for which ONC is seeking advice would need to be split across multiple Workgroups.

And so ultimately as we've taken a step back we believe that if the Standards Committee Workgroup structure will continue to need to evolve over time, not today, not tomorrow, but over time to more effectively and efficiently respond to certain types of questions on which ONC would seek advice. Next slide.

So we propose that as part of this continued evolution, it would be modeled off the successful Task Force approach that we've implemented in the past the JASON Task Force being the most recent example. So where ONC has a question on which we would seek the Standards Committee's advice we would assist with the formation of this interdisciplinary Task Force.

So, first, as many of you know, we've created a Steering Committee under the full committee, so first we'd go to the Steering Committee to discuss the questions on which we would seek advice. The Steering Committee would help propose Co-Chairs for Task Force and potential members from existing Workgroups as well as outside subject matter experts that could be added and supplement the Task Force.

The third would be the formation of this Task Force would be brought to the Standards Committee for a full blessing and they would be given a specific question or questions on which to issue recommendations to ONC through the Standards Committee and a preferred deadline on which to provide those recommendations.

The Task Forces would then go forth, they would conquer, they would present their recommendations to the Standards Committee and a plus or minus, you know, a month or so from the preferred deadline and then when the Task Force had completed its mission it would end unless there were additional work or follow-up.

And so the idea here and what we believe and why we think this has some advantages and efficiencies for the Standards Committee, as well from an ONC staffing perspective, for the Standards Committee a time commitment for either members of the full committee yourselves or those that are part of Workgroups the time commitments for those folks are clear relative to specific questions and deliverables and recommendations that need to be issued.

It can allow for the Task Forces to be formed as needed to take on the full scope of a question rather than it being split across multiple Workgroups and for subject matter experts to be added as necessary to deal with discrete topics.

And then lastly, from an ONC administration perspective, ONC can ensure that we can best fit the staff person to the Task Force based on their expertise and so those are a few aspects in play relative to the work that we see going forward.

So, let me just go through a real quick example on the next slide and since there are no animation I don't have to worry about saying next, next, next.

So, you know, again number one we'd identify questions, we'd bring that to the Steering Committee, the Steering Committee would help identify Chairs for the new Task Force and work on the membership of that Task Force, that would subsequently get brought to the Standards Committee for approval, the Task Force would be charged, they'd be operational for a period of months to work on this discrete question and deliver recommendations back to the Standards Committee and then subsequently the Task Force would end. So, continue forward, please.

So we have a few interdisciplinary questions that, you know, when we look into our crystal ball and we see the work going forward there weren't necessarily a specific Workgroup as it had been formed or the requisite disciplines in one Workgroup to take on some of these questions.

And, you know, these are three questions that we've since put together on which interdisciplinary expertise would be desirable as well as feedback from the Standards Committee. So I think you can look to these as probably our top three questions in the near-term that we'd like to use this efficiencies and Task Force approach to address. One last slide for me.

So, next steps, there is a lot of work that staff have already been doing with the Workgroups as they're currently constituted and those workgroups have a bunch of stuff that's coming down the pike that they're going to need to chew on including the interoperability roadmap, subsequent rules as they come out and other work that's already on their plates.

As we look forward and start to work with the Steering Committee at the end of this year and into Q1 I think that's where we'll be starting to prep for some of these new Task Forces to be formed to take on these interdisciplinary questions.

And as Q2 approaches in 2015, I'm on the calendar year for anyone that has needed to know if I was talking about fiscal or calendar, for calendar year Q2 where a Workgroup as it is constituted today has unique or single scope issues it would continue to work on those and then where there are needs for interdisciplinary input as necessary then that would be our kind of general go forward approach and that's our kind of operational efficiency proposal for the Standards Committee to weigh in on.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So, Steve, to just summarize that briefly, there were some objections voiced when we announced the Workgroup redesign that things like content semantics could not be separated into discrete Workgroups.

So what you're proposing is depending on the nature of the question the Steering Committee may draft certain members of the Workgroups as they've been redefined to join a time-limited Task Force that therefore would ensure that all appropriate stakeholders on a particular problem are represented, answers would be forthcoming and then the Task Force would be dissolved.

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

That's correct.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Is that correct?

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yes, yes and that's an area where, you know, as we've discussed multiple examples you can't really talk about the Consolidated CDA without talking about semantics and, you know, content and semantics has been an area where we've seen a lot of potential for overlap.

I think others have raised, you know, questions relative to how FHIR or particular FHIR questions might be addressed if they were so asked for in terms of advice from ONC. And there are a number of areas where I think if there is a crosscutting issue our tendency and bias would be toward forming a Task Force of the interdisciplinary experts as opposed to trying to split it across multiple Workgroups or having one Workgroup take it on.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And another example, just as Dixie made the comment that she thought digital signature was good for some purposes but not others, you would imagine that even though FHIR might fall into a content area, if in fact the provenance and digital signature was a critical component of that content that you would involve Dixie and the Privacy and Security folks and therefore that might fall into a Workgroup for discussion.

So that's the proposal on the table that we form our existent committees, subcommittees as articulated previously but also have the ability to form agile Task Forces as are necessary for multidisciplinary issues and the Steering Committee would help with that. So, comments, thoughts, Michelle do we folks in queue?

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

David McCallie.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Go ahead, David.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Yeah, I'm batting 100 or 1000, maybe 100. I mean, I think, you know, the trade-off between vertical and horizontal structures in any complex space is a common problem and this makes good sense because it's got the flexibility to, you know, shift modes.

My only real concern is just the aggregate impact on time of everybody so if you are on a Workgroup that's meeting regularly and you're on a couple of Task Forces which are meeting regularly and you are trying to track progress of some S&I Framework activities which meet extremely frequently then it just gets overwhelming. So, we have to be real careful about time.

Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yeah, I couldn't agree with you more David and I think part of the idea of having the, you know, Task Forces focus on discrete questions with time bound commitments is to help address that concern as well as for us and I think a role for the Steering Committee is to help load balance how many of either Task Forces or Workgroups are active at any given time focusing on responding to questions from ONC on which ONC would seek advice.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Thanks.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Of course we run the risk of assigning Dixie Baker to every single committee and every single Task Force as has happened in the past. Other comments?

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

There is no one else in the queue.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Wow, okay, well we might actually end on time. So I would say that lest folks get too worried about the complexity of this horizontal and vertical structure I think all Steve is saying is that it is a construct which can be optionally used as needed where there are multidisciplinary questions to answer and it may or may not be used we will see the nature of the questions and the Steering Committee can certainly weigh-in.

Well, good, well I think Michelle then we have covered all of our material today and so we want to open it up for public comment before we break and wish folks a Happy Thanksgiving.

Public Comment

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

Operator can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-6006 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.

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

We have no public comment. So, thank you all. I wish you all a very Happy Thanksgiving and as we said at the beginning of today's meeting Jacob you will be sorely missed and thank you for all you have done and I will personally miss you greatly.

Jacob Reider, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you Michelle and thank you to the Standards Committee for your kind words today and for your hard work past, present and future.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very good folks we will see virtually in December unless ONC has decided to change that I believe our next meeting is virtual.

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

Yes.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very good.

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

Thank you.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you we are adjourned.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Very good.

John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation

Bye-bye.

M

Bye.

W

Happy Thanksgiving.

Public Comment Received During the Meeting

1. Hi all, I am having to monitor this concurrently with a NIST Big Data meeting, but would like to be involved in security & privacy stds work, which is what we're doing in that PWG
2. In that case you need my contact information: mark.underwood@kryptonbrothers.com and the NIST working group URL is <http://bigdatawg.nist.gov/home.php>
3. Note that the Start Point is not necessarily the point of data origination (the original provenance event).
4. The DPROV UML diagram has recently been supplemented with designation of the provenance events (not shown on this slide).

Meeting Attendance				
Name	11/18/14	10/15/14	09/10/14	08/20/14
Andrew Wiesenthal				X
Anne Castro	X		X	
Anne LeMaistre	X			X
Arien Malec	X		X	X
C. Martin Harris	X		X	
Charles H. Romine				
Christopher Ross			X	X
David McCallie, Jr.	X		X	X
Dixie B. Baker	X		X	X
Elizabeth Johnson	X		X	X

Eric Rose	X		X	X
Floyd Eisenberg	X			
James Ferguson			X	X
Jeremy Delinsky	X			
John Halamka	X		X	X
John F. Derr	X		X	X
Jonathan B. Perlin				X
Keith J. Figlioli			X	
Kim Nolen	X		X	X
Leslie Kelly Hall	X		X	X
Lisa Gallagher	X		X	X
Lorraine Doo	X		X	X
Nancy J. Orvis			X	
Rebecca D. Kush	X		X	X
Sharon F. Terry			X	X
Stanley M. Huff	X		X	X
Steve Brown			X	
Wes Rishel	X			X
Total Attendees	20		22	21