



**HIT Standards Committee
Implementation, Certification and Testing Workgroup
Final Transcript
April 27, 2015**

Presentation

Operator

All lines are now bridged.

Michelle Consolazio, MPA – 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's Standard...I'm sorry, Implementation, Certification and Testing Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also, for those of you who have used the comment box in the past, we are going to start to read those comments out loud during the public comment period, so just be advised that anything you put in that public comment chat may be shared. And I will now take roll. Liz Johnson?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

I'm here.

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

Hi, Liz. Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'm here.

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

Hi, Cris. Andrey Ostrovsky?

Andrey Ostrovsky, MD – Chief Executive Officer – Care at Hand

I'm here.

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

Good afternoon. Danny Rosenthal?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Here.

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

Hi, Danny. David Kates?

David Kates – Director of Interoperability – The Advisory Board Company

I am here for now.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Good. Yay.

David Kates – Director of Interoperability – The Advisory Board Company

But not for long.

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

John Travis? Kevin Brady?

Kevin Brady, MS – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology

Here.

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

Hi, Kevin. Kyle Meadors?

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Here.

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

Hi, Kyle. Rick Moore?

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Here.

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

Hi, Rick. Sarah Corley?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Sarah. Steve Waldren?

Steven E. Waldren, MD, MS – Healthcare IT Strategist & Physician Informaticist – American Academy of Family Physicians
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Steve. Udayan Mandavia?

Udayan Mandavia – President and Chief Executive Officer – iPatientCare
Yes, here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
And Zabrina Gonzaga? And from ONC, do we have Brett Andriesen?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology
Yes we do.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Brett. And is Scott Purnell-Saunders on as well?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services
Scott is on the call as well.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Scott. Anyone else from ONC on the line? Okay, I'll turn it back to you Liz and Cris.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation
So Cris, I'm thinking given David's limited time, we probably ought to get to the heart of the matter as quickly as possible and then come back and sort of look at the timeline and future assignments and that sort of thing. Is that acceptable to you?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Let's go. Just right, do it.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, I would say start with David with slide 6.

Sarah Corley, MD, FACP – Chief Medical Officer –NextGen Healthcare Systems

I'm not online, I'm sorry.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah and I'm not online either; so I'll make some comments while you're pulling that up. So with HIMSS and with other excuses, the dog ate my homework, a variety of other excuses, the...what I did Sunday, just in time, was go and contribute my own individual comments to the sections that my subgroup was assigned. So other members of my subgroup number one, I apologize for not...to the input that you provided, if you can articulate that. They may already be in the slides or as we go through the discussion.

And what I thought we would do, while I'm on the phone, and even while I'm off, is we can just tee up each of these topics as much as we can get through today for discussion of the group and I'll turn it back to you Cris and Liz a little bit, just to make sure level set while we're on topic. But, what we prepared was just feedback for the sections that we were assigned as to the types of guidance that we want to give back to ONC related to the relevant topic. So, we can just...them, if that's okay.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Absolutely. Yeah, and I think you're online. I mean I think the idea is let's just get the conversation started and we can wordsmith and make everything seem more like the consensus of the recommendations going forward.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah and then based on this discussion today as well as the other groups, I will submit...we'll schedule some time for my subgroup including inviting Sarah and John and others that want to participate, we'll make it known for the rest of the group, to just go through and refine the comments and come up with a refined thread of feedback for these topics.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Great.

David Kates – Director of Interoperability – The Advisory Board Company

So, just jumping right in the first one, just I'll tee it up and then see if there's discussion, is...I mean the topic...the section on page 14 talking about the cost of this being over 100 million I think is sort of administrative, regulatory requirement that's saying that...making that statement that it's over 100 million puts into a category where it requires a level of scrutiny. So, the key point that I tried to articulate is that absolutely it's more than 100 million and frankly, it's more than anybody estimates given all of the direct and indirect costs associated with all the certification stuff. I'm sure that Sarah can comment to that effect, but I don't know that we need to belabor the point.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah Caitlin, you want to go to the next slide, please, so we'll...I think he's on slide 7 now. Thank you. Okay.

David Kates – Director of Interoperability – The Advisory Board Company

So Sarah, I mean Cris and Liz, like I don't even know if it warrants a lot of attention, I think...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

No I would...

David Kates – Director of Interoperability –The Advisory Board Company

...the fact that it's over 100 million is...puts it into a category...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

This is Sarah. I would say to this point that we have universally throughout the course of Meaningful Use seen underestimates in terms of development costs and timelines. The EHRA did provide realistic estimates for the old 2015 version, which was not adopted but was made 2014 R2 so that we know that ONC had time estimates for those items from the vendors, which were based on our experience.

However, there are a lot of new functional requirements in this NPRM which are definitely underestimated in terms of development work effort. For example, some of the areas where they asked for questions such as the ability to support screen readers could require complete re-development of certain EHR products, which would be tens of thousands of hours of development work. So I know...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So maybe...go ahead.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...the EHRA is planning on providing revised estimates to ONC in their response to this so, I think if we just leave it as saying that we think that these estimates are low and we will await feedback from industry that has a more realistic evaluation of the time needed.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So I would just add a couple of things; one is, as we do through the proposed rule, if there are areas where any of you see significant development...potentially significant development costs involved, we don't have to quantitate it, but we could at least acknowledge it. And the second thing is, I saw on the slide that you put out Brett that you wrote down and then write quantitative benefits, is that...where did that come from?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yeah, that was from comments I believe that Rick had submitted. Rick, are you on to kind of further elaborate on that point?

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Yes. Yeah, I'm here. So if we have national kind of a return on our investment; if we're going to put all this money, what are we trying to get out of it from a national perspective in terms of the cost ratio benefit value basically? What are we going after here, so some way to tie that to the effort involved here?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So Rick, sounds like it's as much...it's an acknowledgement of the need to do that and then maybe some suggested areas where we could determine actual measurable benefit.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Right. If there was some way to tie that together that would, I think, add a little bit more meaningfulness to it, yes, as opposed to just do it because it's good for bus...or you know, because it makes sense.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, this is Sarah. This is something that providers have asked for for a long time, in terms of the quality measures, to say that before you decide on something that's going to disrupt the workflow and add to work, you should be sure that the return on investment in terms of improved health outcomes, improved efficiency, the whole triple aim...

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...that we're really meeting that by this rather than I know I saw some comments that all of these requirements in the NPRM were things that customers had asked for. Well if you look at in terms of buying a car, I'm sure customers ask for fancy rims and heated steering wheels, but that doesn't mean that that's in your base model car. And so there are a number of items that don't have the return on investment to the whole healthcare enterprise that you would expect for mandating something to be in all electronic health records.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

That's where I was trying to head with that exactly. Yup.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So this is Cris; I think as we go, we're going to want to capture some comments that we think are germane to put at the top as kind of overall findings. For those of you who were at the last Standards Committee meeting last week, I think one of the topics that Liz and I raised in our update, and it generated some input and energy was the question about all of the ideas in Meaningful Use 3 appear to be relati...you know, good or great and maybe there are some ideas that aren't so good and we'll

comment on those. But that doesn't take away from the fact that in aggregate a bunch of good ideas do not make a great program and that it may be too much for us to absorb.

So I would offer up as a category that we may want to offer as overall comments, some commentary about the overall effort and burden required by vendors and EPs and EHs as part of the Meaningful Use 3 Rule. And I would love to hear some feedback about that, around whether we think that that's a candidate overarching comment.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Currently...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah Cris, this is Dave.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah.

David Kates – Director of Interoperability – The Advisory Board Company

I mean I think actually some overarching comments about the rule would actually...because I...as I was going through the individual sections, there was a consistent theme along the lines of what you just described that a lot of the intent, you know, complementary to ONC and all the hard work, etcetera, etcetera, and that the spirit of the changes are directionally great and with good intentions, but there may be unintended consequences of whatever, however we say that that there are other thing...other considerations that will contribute in the body of the remainder of our comments related to nuance. But overarching, understand the intent and think directionally there are positive elements to it and the comments then focusing on those areas that warrant specific attention.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So Brett, we might wa...I agree with both comments and absolutely believe that even though I think all of us think these are great ideas, we are trying to figure out how we're going to get it done. Brett, can we start a list of just sort of general comments and then when we roll our entire presentation together, whether we start with those or end with those or both, those...these would be sort of the overarching themes. And one of them would certainly be the balance between the benefits that we get from reaching all of these lofty goals versus the cost and time and commitment that are required.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yup, we can certainly do that; I'm making notes here of some of these overarching ones and then some that are specific to the individual topics or criteria. And we can certainly elevate those overarching ones to the top, but we're taking down notes of everything...

David Kates – Director of Interoperability – The Advisory Board Company

Or we can take the Jonathan Bush posture, but I won't say it out loud because I'm getting recorded.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

This is public, David, it's public.

David Kates – Director of Interoperability – The Advisory Board Company

Exactly.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

That's right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And that never stops Jonathan, but...and I say that admiringly. Brett, this is Cris, if you could keep that list going, I think it would be worthwhile for us to put that somewhere in our review documents as we have these workgroup meetings, just so we can remember what the overall kind of emerging themes might be, and that as an individual or a particularly detailed topic comes up, we can note for ourselves, do we want to bring some of this comment up to a super-level as opposed to a detailed level.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Good idea.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Shall we move on to applicability?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

David Kates – Director of Interoperability – The Advisory Board Company

I'm going to lean on Sarah for the next one a little bit, too and others. But, I believe the next section was the commentary related to expanding the scope of the rules beyond just the...and the ambulatory setting, some of which was definitional, but some of which implied that we want to create regulatory structure for supporting the adoption of health IT in settings outside of ambulatory; long-term care, other types...medicine, etcetera.

And the general comments and I'll then tee it up for broader discussion was that while it's a positive development to recognize that care goes on in all sorts of different settings and the adoption of health IT has benefits in those settings, but that needs to be balanced with focus and recognition of sort of what the current baseline is and what's feasible in the context of where people are today in some of those settings that had not had significant investments in health IT to date. So, I'll pause and Cris, Liz and then I'm sure Sarah will have some comments undoubtedly.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Sarah does have some comments, what a surprise. So, if we are looking, I certainly loved the expansion of health information technology into domains where it's currently underpenetrated, areas such as long-term care. But one has to; again, assess the level of work, the return on investment here. Because long-term care for the most part is not part of the Meaningful Use Program, not subject to the incentives that

are now over or nearly over or the penalties, they don't have a mandate to adopt health information technology and as such, they don't require that there be a regulated or certified product right now.

Now, those of us like David and I that date back to the CCHIT world, we did have certification for long-term care as a goal of creating a specific set of requirements so that a product that was certified to those, a purchaser would know that it would meet certain core functionality that they need. I don't think that that's a bad process, but I think that when you're talking about developing requirements that a public-private stakeholder group that determines that there is a need and that by fulfilling the need it's going to increase adoption, should be creating those. But to talk about putting them into the Meaningful Use Program when those care settings are not part of the Meaningful Use Program seems to me a lot of effort on the part of ONC, with a scarce budget, that they might want to devote to other areas that might have a greater return on investment.

So the short thing is that I applaud the attempt to expand health IT into these underpenetrated domains. I don't think that creating meaningful use certification requirements specific to them is going to help that and particularly if you don't limit those to a core minimum set specific to that, you can lead to confusion as to exactly what products a user needs to purchase to meet their requirements for the program they're participating in.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah and one of the things that we've heard before from this group and others is there's a concern that there will be additional cost that the vendor will bear, therefore will pass on to the buyer for a certification that they don't need. And so there's been, you know, this sort of balance, that is tenuous at best saying, where we...no one's opposed to the concept per se, but I think you're right; between the confusion as to why we need this and the potential for added cost when they don't need it, causes great consternation in some of those organizations that we're talking about.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Well this is Kyle; I just, I mean, this section, this applicability section, I mean it is some degree just a regulatory kind of our activity of, where they're trying to remove some of these references as they are now. So I don't think that it's so much that they are in this part that we're commenting on, moving into new areas, even though obviously allude to that. It's the fact that we've got currently in rules, we have something that says inpatient only or optional. We're now trying to, I believe, remove those terms and just simply make it the criteria which speaks to itself and obviously in settings and can be applicable maybe across multiple settings or just trying to remove those terms. I guess it's more of the idea these are roadblocks to any future expansion as opposed to direction right now. I mean, I don't think as it sits right now, you still have to do some of the analysis of do I need this certification or not. So I mean, I just think this is more just trying to clean the language up more than anything.

I mean, I will speak to myself as a...from a ACB side of things, we have a lot of vendors who come through and they want to let their product certify for something like patient education or something and something somewhat general, but they want to make sure they get two certifica...certificates; one that says ambulatory and one that says inpatient. Because as of right now, you do have to distinguish the two and I think it would just help just to remove that and simply here is what you're certified on. Obviously certain settings may need certain things, and there are some references to that in the criteria still, but...I mean, I think it's just more of just trying to make the...I could use the term, more agnostic, more than anything.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

But don't you think that...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, so I think our comments reflect that...this is David again real quick. So that was partly how this was presented was mostly semantic or some definitional stuff that was for regulatory reasons and so we can...if you can help us describe that and what the intent is. But then I think it's still noteworthy to add some of the other commentary related to being cautious and how it might be interpreted like this group is interpreting it that for that purpose fine, but just let's make sure we're not...ourselves to the industry and the community that...attack a broader set of things just yet.

M

Yeah, and this...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I would also say that by removing that, I think you do add some confusion to the purchaser of the product because it's not quite as clear what they have to have for their particular domain.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

I think that was a cautionary note we were trying to articulate was that I think the direction we all welcome is the inclusiveness of all technologies required to make a community, if you will, to get to reporting and all that good stuff. It's not one system, I think they were trying to break away from that terminology. But now you've got this phenomenon where people might buy systems thinking they get it all and they only get a third of what they need.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

And this is Scott from ONC...

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

How do you bridge that gap?

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

Yeah this is Scott and that was...being sent there was to try and clean that up. I mean we've seen a lot of instances where, I mean Kyle is more witness to it directly as well, but we know that certain products are literally certify the same way twice. I mean folks don't have a clear understanding of what the program requirements are necessarily other than the fact that they see a product that says ambulatory versus inpatient.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So it sounds like we'd want a combination of both comments, David and Sarah, like you said...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

...one would be around the appropriateness of being inclusive but also being cautionary and what that might entail. Is that fair?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yes.

David Kates – Director of Interoperability – The Advisory Board Company

Yup, that sounds fair. Should we move on to the next one or...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

I think we should.

David Kates – Director of Interoperability – The Advisory Board Company

So I have as much a question as a comment; so, I think the next topic that we tackled was around limiting certification to just the delta or the gaps from one testing to another. I don't know if that's...from MU2 to MU3 or whether it was in the context of like a new release or a new version of product that's going through the same level of certification.

But in either case, I think the intent is positive and is responsive to some of the concerns that the industry's raised and just should be done in a way that's cognizant to make sure that the buyers are protected, whether it's through attestation or through some other mechanism but...or other mechanisms described in the rest of the reg, that there, you know, for us to verify that if, in fact, all your testing is the incremental stuff, that there is a way to ensure that there hasn't been any regression of the underlying stuff that's claimed to be intact. Full stop.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, this is Kyle. This is a little difficult section to comment on because at some degree it's related on other...it's impacted by other decisions, so I'm meaning if they make CPOE A.1 gap in that section, which we're not reviewing, then you also have to reflect it here in this section, which is just a table of it. And so, you know, we've been doing the gap approach already in 2014, it's obviously going to expand here in 2015 and I would point out they are, you know, looking ahead a little bit to the open CHPL discussion, wanting to put in there more clearly, where you can basically identify criteria that are, they're called gap certified.

Which essentially means, for those who aren't familiar with it, it wasn't because the...it's really more no gap, that's really the right way to say it, there's no gap between the previous edition and this current edition, therefore they're connected the same, as long as your product has not changed in that area and functionality has not changed, you can inherit the certification from one set of criteria to the next. And we've been doing that in 2014, again in 2015 here, it would be expanded a lot more, there were something like 11...9 ambulatory, 11 inpatient possible choices in 2014 and it's obviously expanded quite a bit here.

But I do think it'll be, with this new open CHPL concept, more freely label one, when this stuff was, what was gap certified and then two, I mean I think gap certification just means it's eligible, there still has to be an evaluation that the ACB does and so it's basically like inheriting any, like right now, if you're a certified 2014 version 2, now you're going to 2.1, you submit some...at least a request for inheritance and you attest to these various changes you've done or not done and those are evaluated. So gap is really kind of part of that process here. I know this is a little more kind of educational than anything, but I mean I don't really think there's a lot to me in this section that can really be commented apart from, I mean if they decide not to change a criteria, then it's a definition gap.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

So I think, that's o...this is Rick. I think one of the concerns that I read, I think from your read there Kyle, you're talking more from a testability perspective, right, testing gaps?

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Right.

Rick Moore, MS, PhD, FACHE, FHIMSS, CPHIMS, PMP, CISM – Chief Information Officer – National Committee for Quality Assurance

I'm thinking more of, okay, so now I'm going to go out and buy one that's been tested or install one that's been tested fully versus one that has only...that has gaps still remaining. Are there unintended consequences of a system interacting with a gapped versus a non-gapped system again? That's sort of the concern I think I see.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

But that's not what the gap is though.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, I think the gap was more deltas, not that there was a hole, but in fact that all that's being tested is what's different about a previously tested version from this version or the previous certification levels from this certification level. So there's not...and there's not a deficiency in functionality it's just an ar...it's a methodology in terms of testing to just test what's new or what's...what needs to be tested that goes beyond what was previously tested.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah I mean, the testing is very expensive; it's very time consuming and it's very expensive so the purpose of this is to not have to retest when the test steps and the measure has not changed and you have not changed your product. If you changed your product, you have to recertify and if the measures have changed or the tools have changed or whatever, then you have to recertify. But this is simply trying to reduce the burden of not requiring re-certification on something that has not changed on either end. So, from that standpoint, you know, I absolutely support not having to do redundant testing.

David Kates – Director of Interoperability – The Advisory Board Company

So we might want to think about, I don't know if you want to make a recommendation but gap is the wrong term and it's incremental or something like that, but I'm not the semantic wizard.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

No, I mean, I actually...sympathetic to that, given how many gap evaluations I've processed in the last couple of years and thinking the s...at this point, I think it's almost the ship has probably sailed, at least from the vendors standpoint. The term we use, I mean, I'm not as I say opposed to it, but I think most people now hey is that gap, is that a gap eligibility...

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, I think it's identified in gap so that like those of us on this phone call that are in the weeds can understand it, we may just want to have something out there in community that responds exactly per this discussion of what it means and so that it's not inappropriately.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Probably the better way is just simply saying the criteria is identical to the previous iteration, like 2014 to 2011, 2015 to 2014. So really just saying the functionality is unchanged, it's...or criteria is unchanged, same functionality is required and therefore as long as the product is still...has not made changes in that area, then there's no reason to retest them we can in a sense we can call it grandfather or inherit in the certification from the previous evaluation. So...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So let me ask as a buyer then, can I then assume that if we move from version X, Y, Z to A, B, C and the vendor attests, doesn't test but just attests to the certifying body that no changes have taken place related to MU and therefore the product is certified and I can use it as such to attest with instead of, I don't know if I said that clearly or not, but...

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Basically yeah, I mean so like for example, a vendor comes and they request this gap inheritance for CPOE, for example. We then evaluate that, we say yes, that's...we believe you're correct, you did not make any changes, you obviously were certified in 2014 on CPOE therefore when we issue the new 2015 edition certificate, it will show that its certified in A1, just like if we had tested it. So it has equal standing so you as a user should have equal confidence in that it's been...that it's certified, that it's compliant. So that's kind of the...that's from an end-user standpoint, you should have the same level of confidence if it's marked as A1 whether it was tested of gap inherited.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Liz, this is John; something I want to make sure you weren't asking, I'm sorry I joined late. But I want to draw a difference between gap certification and a vendor doing an update to an existing certified product under the same criteria edition where the vendor is asking, through the product update process, to be granted for lack of a better term, I've always used the term inheritance relative to the new version. And then the ONC ACB will review what evidence the vendor will provide to...but largely to assure themselves of the same thing, that there's been no material changes to either disable, remove or substantially and materially alter the functionality that was subject originally to certification.

So there's kind of that that operates within the same criteria edition that we always have done and then this gap certification relative to new criteria edition for criteria that has not changed from the prior criteria edition. I will say, at least it's been past practice though, even with this, this speaks of the functionality; we may still have to test for measurement related to an objective that the capability ties

into and CPOE being a good example. If the numerator and denominator statements actually were to change...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...then we would have to retest to that. I'm sorry, we would test anew to that in that criteria edition.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right, it wouldn't fall under gap.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Right, that...yes.

David Kates – Director of Interoperability – The Advisory Board Company

Umm, it's Dave again. I think we've got the key points, just in terms of applauding ONC for being cognizant of all the costs inherent in this and this is an approach and we just, you know, we'll rearticulate and bring back to the group sort of the cautionary stuff that we've discussed, I think we sort of touched on all of those topics at this point.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

David this is...

David Kates – Director of Interoperability – The Advisory Board Company

...propose we move on to the next one.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

David, this is Cris, I'm sorry to slow you down, and I like moving forward...

David Kates – Director of Interoperability – The Advisory Board Company

Oh, that's okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...just did we address the issue about how much discretion to delegate to the ACBs? Is that relevant at all here and do we want to comment on it?

David Kates – Director of Interoperability – The Advisory Board Company

I don't think we did address it, so if there's discussion...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

We did not; you're right Cris, we did not.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

This is Sarah; I certainly have some thoughts here. You want to minimize variability between certifying bodies so that you don't have shopping across different certifying bodies to find the one that's going to be the easiest one or have vendors being held to different standards. So to the extent possible, it's good to have clarification as to when you must or must not recertify. And I know we've had issues before about patch versions, which generally are just bug fixes and don't change functionality and there might be differences of opinion across the certifying bodies as to what requires actual retesting or not. And Kyle can probably speak to it more eloquently than I can, but I know that among the vendors I have heard tales of very different methods of handling this across the different bodies.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's why I asked it and I think we should ask Kyle if he's got any comments about this in particular.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Well, I mean you're welcome...I mean certainly it's...welcome to make a mention of that, I mean, for that matter, I think the bigger point would be ONC obviously it's accreditation group at ANSI should make sure that the ACBs are behaving consistently period; you know, not just gap here, but across other areas, too. So, I mean, I think that's a worthwhile comment in general, obviously I support it. I mean...but I think to this specific situation they do kind of believe gap, and this is really more referencing what they call the permanent program or used to be the permanent program rule, describing the certification requirements.

So not necessarily the quote unquote ONC criteria as we talk about it, but it's still on the table, I mean, so...I mean, I feel kind of biased in terms of what I would say here. I mean, we certainly welcome any guidance that ONC would give on this in terms of how we do. I would say for generally practical purposes for Drummond Group, we rarely, if anyone attested that they did not make changes in the gap 2014, we just simply accepted that without a lot of debate, so to speak. The only times we would maybe do that is if we knew they changed like ePrescribing vendor or something, obviously then you're...probably what you use for CPOE is a little bit different here in that case. Something like that might come up, but by and large we simply took it in. Because if we kind of had a test to do, I mean what John mentioned, too; one thing our take was, we would test you anyway when you did the G2 stuff for a lot of these things, so, we already were seeing the functionality anyway; having to go through it for us didn't seem to have a lot of value.

This may be a little bit different with 2015, it's a lot more expanded, so, I mean we only had like I said about 10 choices before. So, I mean if you want to mention that, I mean I'm certainly...I would not be objected to that; we should be consistent.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

This is John. There's going to be a point for my work...my sub-workgroup where we got the item, I believe it was in some of the...it wasn't the open CHPL, but it was more on the point of reporting monthly updates and it was under the SCD testing, but it got into some things in the NPRM about reporting intervals of updates to ONC ACBs that vendors make as it...kind of as a crossed over into

surveillance but it was intended to support a point of judgment about did updates affect the usability testing and safety-enhanced design testing.

We will get into this topic there more from the product update perspective and a little bit on how versioning is currently handled on the CHPL and maybe looking to normalize how doing version updates for things that were to be minor are handled. So, just wanted to footnote that we'd be getting into this in...from that perspective in the May, I guess it's on May 8.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So if we believe that there's potentially diversity between the certified bodies or we don't believe that, we should bring it up as sort of the consciousness of the group. You know, generally speaking when we bring that kind of potential concern, we try to offer a suggestion; I'm not sure how we would fix that, other than just saying, I don't know if we have actual facts that there are differences between the certifying groups or not. Cris, do you know? Or Sarah, is it more a...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well, I'm not sure that we, I mean, we could if people had strong...comment on about the degree of variability. I think the point to be raised is Sarah's which is, consistency across testing bodies would have some merit to it. And I think the other issue, just broadly speaking is, if we're coming back to ONC, I think part of it is, how prescriptive do we want to...would we advise ONC to be around establishing exactly how to handle gaps, whether that's...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...something that they want to prescribe specifically or whether they want to delegate that to the ACBs, in context.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

This is John. Cris, there's probably a level of discretion you want to preserve; I mean if the vendor...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...doesn't present good evidence that things haven't changed, then I don't think we want to say to the testing lab or the certifying body, don't do your diligence; if you fail to see adequate proof that the functionality has pretty much been left intact. And I think we want to allow some discretion if part of it is, you know, the functionality's substantially been left intact and you're not...what work you did didn't materially change the end-user experience.

We will, again, get into some of this when we talk next week on versioning, because I think there are some things that can stand to be more consistent that are fairly inconsistent right now as to labeling and how versions are represented on the CHPL. And then that may also go towards some of the SED requirements themselves about how to regard materiality. So, I think materiality of a change is a bit subjective right now and there's a more specific question in the SED space; basically, when does SED testing need to be redone because of the degree of changes made to the end user interface that we might take up and want to hold some of these thoughts for where I do think there is probably more opportunity to make suggestion about the consistency point. But on gap certification, I think it's mainly just one of maybe standards of...levels of diligence at most, but not taking the discretion away from the certifying body to exercise their diligence.

M

It sounds to me like we're making a recommendation, there should be some form of standardization on how a vendor attester, pardon me, assesses against a vendor.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, I mean, standardization or, yeah standardization or a defined set of criteria...

Multiple speakers

(Indeterminate)

David Kates – Director of Interoperability – The Advisory Board Company

...just some sort of...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, I think defined set of criteria is better because you're not going to find standard ways of naming conven...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare System

...for vendors or product releases, so.

M

I'd agree, yup.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

All right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay, I think we've zeroed in on that one, that's helpful.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, that was...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Should we move on to clinical data sets?

David Kates – Director of Interoperability – The Advisory Board Company

Sure, so I'll tee it up. I hope I didn't go beyond what I was supposed to have reviewed, because there was quite a lot of meat in this section. But the, I mean the initial paragra...I think there were four topics. I don't know if I was supposed to comment on all four, but here we go. I mean one was semantic, I think, although again, even just semantic changes might have consequences, so going from MU data set to clinical data set seems definitional and fine and relatively harmless, although we might find harm there.

And then the three things I think that were of substance further on were vocabulary standards and, I'd welcome input from the group in terms of any impact of those. And specifically in that area, vocabularies related to immunizations. And I will invite Sarah to comment on immunizations as well as the next topic, I'm just going to tee all these up because I may drop after...as we get into the discussion. The other topic of medical devices and unique device identification and then the last topic in here was expanding some of the areas that are covered under the data set, specifically around assessment and plan, treatment goals and health concerns. And I wasn't completely sure whether that was the release 2 stru...additional structure in release 2 version of the C-CDA or whether it was trying to define something beyond that.

But those seemed like the four topics; the definition change, the vocabulary change, specifically immunizations. Third, device identifiers and fourth, the additional areas like treatment and plan. So, open it up to disc...I mean, maybe we can knock each one of those out if those are all...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well I'll start with the unique device identifier...

David Kates – Director of Interoperability – The Advisory Board Company

Okay.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...one of my pet...

David Kates – Director of Interoperability – The Advisory Board Company

Are we okay...before we go there, is the definition going from MU data set to clinical data set, is that defined enough that we...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I don't think we need much comment.

David Kates – Director of Interoperability – The Advisory Board Company

Okay, good. I agree. Any dissent? Okay. Cris, Liz, are you okay going on to the device?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Absolutely.

David Kates – Director of Interoperability – The Advisory Board Company

Okay.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

So the unique device identifier is problematic for a few reasons. The idea of storing a field for a unique device identifier is not problematic that would be very little development work. However, it's been over-specified. It's a requirement that does not have a matching meaningful use criteria, and I would like that to be an overarching comment that we make is that if there is not a meaningful use requirement for an eligible professional or an eligible hospital, it should not be a certification requirement because vendors need enough time and bandwidth to develop what our clients are actually asking for, our individual clients and not what someone might be lobbying ONC to include.

The unique device identifier is not an area where we're hearing a tremendous request for inclusion on the part of our clients. If we were to do so, to just simply put in a field for the number and the name of the device, I should think would be sufficient and not all of the additional requirements such as parsing out codes from device identifiers to figure out what they are. This rule from the FDA had a total of 7 years to fully roll out to all devices and it has about 5 years remaining before all devices will be required to have this unique device identifier.

So that means that any development now would have to be ongoing. It would add additional cost to our end-users because of the current way that this is worded it is likely that most vendors would need to contract with a third-party, such as First Databank to provide the services for real time searching, etcetera, which would add to the cost of our product. And when you consider that almost no devices are implanted in the ambulatory environment, other than perhaps IUDs and long-term contraceptives. But you're certainly not putting a pacemaker in in the ambulatory environment and this requirement is for all domains, you would be adding cost to the core cost of the product, no matter whether the product didn't support devices or not, whoever it was tailored to. So, I'll stop now in the interest of time because I think we only have 10 more minutes of David's time.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

This is John, we're also going to get back into that next week. Sarah, a lot of what you said would be echoed with a few additional comments, because we have the base EHR topic, where it's going to show up as a UDI and implantable device by extension is included there as well. And we may want to...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, I was going to say, it doesn't sound like we have disagreement, other than the fact that we're acknowledging that they've got 5 more years before it's really in widespread use. And Sarah, I think you're point is well taken, probably much more applicable to the acute care, inpatient setting than ambulatory.

David Kates – Director of Interoperability – The Advisory Board Company

Yeah, so I'll try and capture this with ONC staff's help that it may be premature and it may be more specificity than either brings benefit or that there's market demand for and try and provide that guidance back to ONC in the group's comments and we can bring that back to the group.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah David, maybe one other thing, and maybe Sarah has a different view of it but when we talked about this in my sub-group we thought also that there may be issues because the information is probably going to be subject to redundant or re-transcription if it's been initially recorded in a perioperative system or some other system; there's a fair probability even on the acute side this information's being maintained in something outside certified EHR technology and in a non-structured form as part of something else. And either there's a re-transcription process or there is a question of how does that data then get into the certified EHR. Yeah, you could submit a perioperative system to be certified to it, but in reality, if we're talking about direct patient care EHRs in the hospital setting, this information is probably living in another system, still within the patient's medical record, but probably lying, application-wise, beyond what to date has been a certified system. So, it raises just questions of the processes for how that information gets into the cer...into the E...what is the certified system without creating burden on the documentation processes.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

So the next thing that David asked me to address was the immunization. So adding immunizations to the core clinical data set sounds like a good idea, except they've added a requirement for including NDC codes and mapping NDC codes to CVX codes. And on this there are several problems; one is that most providers are not actually including NDC codes when they document immunizations, so that would be new development, it would be additional work on the part of the practice to store that information in their inventory control.

The next issue on mapping of NDCs to CVX codes, again, you would really have to show me some benefit to...cost benefit to say that providing the tools to do this mapping is going to be worth the money spent either in contracting with a third-party data provider or developing the content to do this. And then lastly the question is a lot of immunizations required by electronic health records are not actually given in the practice. And so you are recording historical information based off of you know, the mother's card of when the baby got their shots, even though the baby is now 18 years old, etcetera. You neither have the CVX code nor the NDC code for those...vaccinations.

And I don't think that widespread exchange across all of these domains where immunizations may be stored, particularly for these historical immunizations, you allow for this to be accurate and you would be making then assumptions of a degree of precision that does not exist. So unless you're going to limit this requirement for including immunizations on the common clinical data set, you would need to specify that these are only new...immunizations given in the practice and given after a point in time where they will have had the opportunity to upgrade their functionality to include the NDC code as well as the CVX code.

David Kates – Director of Interoperability – The Advisory Board Company

And this is Dave, before I do turn into a pumpkin, echoing Sarah's comments. And Cris, you might remember this from your Surescripts days but, like if we were...I mean, I thought we were going away from NDC codes to more RxNorm, although I don't know if that applies to immunizations but, it...to Sarah's point, we might want to introduce the notion of a representative NDC code or something of that

sort, given the NDC code being a manufacturing code and we don't have that level of specificity. So just some anecdotal data to pile onto Sarah's comment.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

And the fact that NDC codes have historically been reused.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, this is Cris. I think NDC has all sorts of challenges with it, just in general.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, this is Kyle. I would add, we currently, in like 2014 with the transition of care V2, immunization is part of that...now but it is just the CVX code. So, I mean I think that is the...I mean maybe it's...the question should be framed, it's maybe not so much about immunization CVX code but this NDC part. And I mean obviously I can't speak on the challenges of that, apart from what Sarah had said, so, I mean that would be...to me that would be the concern. But I would point out, I mean right now there is, at least in the transition of care part, which I know is not the only thing we use C-CDA for in 2015, but we are currently showing that we have the capability to include the immunizations in that, same thing actually with clinical summaries as well. So...

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yes, I'm not complaining about the CVX codes, I'm complaining about the NDCs.

David Kates – Director of Interoperability – The Advisory Board Company

So, just a point of order...this is Dave, I'm going to have to drop off. If we don't have time for everything and you want to save the C-CDA testing for the next meeting, I'll...that would be topic I can contribute a lot on and you could hit the CHPL topics and others with available time. But, you guys go from here and I will circle back with the group.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Bye, thanks David.

David Kates – Director of Interoperability – The Advisory Board Company

Thanks.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So Brett, I think we've done...Sarah did a nice job of kind of encapsulating, I think, what our concerns are about immunizations and we want to be real clear that we're not objecting to the inclusion, we're objecting to the NDC codes stipulation. Now Cris, of course the next part is C-CD...CDA or C-CDA and shall we move on without David and at least get through the comments that have been made here and begin to capture that?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, I was not in the...I'm unmuted, good. I was not in that workgroup but I'm happy to try and lead us through this. I'm sure others will have comments on it if that would be helpful.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, then let's get going because I know that we have an inordinate amount of ground to cover in the meetings that we have remaining so...the, you know, if we can keep going that's great if you want to lead us through it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I can try. So can we go to the Consolidated CDA creation performance slide? Thanks. So we had a lot of comments on V1 and V2 and I think there were some folks on the line with an awful lot of expertise around that. So the question is around whether the rule ought to have these technical outcomes around a match, around a template conformance and around vocabulary conformance. Obviously these are aimed at being in that same interest of getting us to C-CDAs that are more interoperable.

So maybe we could just go through the comment summary, and I think these are David...are these David's alone or were others on the phone involved in assembling these?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

This is Brett, I think that David again came in a little too late to get into the slides but these comments represent Rick's and I believe Kevin's comments related to C-CDA.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay. So the first comment is the idea that testing for the syntax in the system once is going to signify that the system is capable of ongoing performance and therefore don't need...that continuing to test each functional capability area is repetitive and unnecessary. So, I think what David's getting at is fairly straightforward, so once you prove that you can produce one generally, that that ought to be sufficient. I guess my question would be, whether those who are working with this in practice have found that to be the same...to be the case and whether the vendors are, in fact, producing C-CDAs that are more or less homogeneous across multiple uses or if there is variation by use?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

This is Sarah and as you know, with most of the "standards" that we deal with, they are not completely standard, they include optional fields. And anytime you have optionality, you have room for barriers to interoperability. So unless you constrain the C-CDA, as David and John and I recommended in that earlier workgroup call...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Um hmm.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...you're going to...you know, you could test for 1000 C-CDAs instead of 100 and you could still have some issues. So I'm not certain that this...you know, the goal of testing a 100 and getting a 95% success rate is still going to translate into not requiring tweaks in the field when data's being shared because as long as we have optional fields, that is going to be a problem.

So I think that we're talking about something that has the potential to add a ton of time and effort to the testing and certification process because remember if you're testing 100 different C-CDAs, somebody is going to have to create that content, whether it's on the vendor side if they're receiving this, at a minimum they're going to have the patients to match with the demographic information. And if you're looking at exporting more, again that is a lot of data entry.

And so I would ask whether the level of effort and cost associated with testing so many more is going to have the assurance that in the field these C-CDAs are going to map appropriately. And I do not think that until we further constrain the C-CDA that you're going to have...that more testing is going to result in the goal here. I think this is an area where we have a lot of people working on use cases and trying to come to consensus and I would say that we should further constrain the C-CDA and continue the market effort to harmonize so that the data can be shared. But I don't think that this requirement is going to achieve its goal.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Sarah, just to press that a little bit, is that comment about C-CDA broadly or can...or does it apply against the three specific technical outcomes that are listed here around the reference C-CDA match, document template conformance and vocabulary conformance.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well, I had preferred that David would address this because I am not a technical person, I am...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay, yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I only know what I hear about from our clients and my technical folks which is that even when everybody is following what they're supposed to follow, because of how they might have decided to use the optionality, there are issues in data exchange that require that we modify our product or the other vendor modify their product or we both modify our products. But, there's a lot of work together that sometimes needs to be done.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

This is Kyle. I guess one comment along those lines is, they do reference this C-CDA match and they kind of use this kind of gold standard, reference C-CDA. I guess one question I would have that we would want to make in a comment back is kind of where this would come from? And I think along those lines, kind of a little of what Sarah said made me think of this, that we really need more...you almost need multiple ones or at least defined in terms of a...it's hard to get to say there is the only way to do it, that's the whole point. That's one of the problems, there's not only just one way to do a lot of this coding; there are different pathways.

I think though, I'm not sure on the approach exactly, but I think the intent though is import...we need to constrain things better. There are just too many variability...variations out there and that's causing a lot of problems. There needs to be some profiling or some kind of better restriction of things and just to make this work. So, I guess my, this may be more of a general thoughts on things as opposed to specifically, but I like...I mean we've got to make the C-CDA exchange better but to say there's one little

fix that we can do that's going to affect everything is not, I think, true there are a lot of parts in there, a lot of things people need.

I think this gold standard is a good concept in some ways, but I don't know where that's going to come from, who's going to make that? Is that coming from HL7? Is that coming from ONC? Where are we kind of getting this what we consider is the proper way to encode a C-CDA that we all can kind of look toward as kind of our guidance.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

And I would just caution that people should also remember that you're talking about, whether it's gold standard or not and if we clearly define and constrain this gold standard and all EHR vendors support it because they're certified to it, a lot of the partners in our data exchange are not other vendors. Their HIEs and these HIEs might be using a CCD, a C-CDA, a C32 and we need to continue to support those. And when you talk about interoperability, that's what our clients are thinking interoperability is and when you say, well, it's going to be more work to connect you with this HIE, they're outraged because they think that you've been certified to interoperability but in fact, as is often the case, the partner in exchange is not following the same standards. So, again, I ask what are we hoping to accomplish with this gold standard and are we expecting that anyone other than EHR vendors would be using this gold standard?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Wow, that's a powerful question, isn't it. Wow.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So we should ask ONC probably for some guidance to the extent that they can provide it into the phase rulemaking we're under and if someone on the phone wants to comment, that would be fine. But I think in general the goal here was to get to less optionality and more constraint in C-CDA and the specific three proposals here is this reference C-CDA match, template conformance and vocabulary conformance, which are two general and one specific form of trying to make the structure of the data plus the content of the data more consistent across domains.

I'm afraid I don't know exactly what David has in mind with bullet points number 2 and number 3 around syntax checking and semantic check. If there's someone on the phone who thinks they've got some insight into that that would really be welcome.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

I imagine what he was speaking of the third bullet at least was with especially the document template conformance for all the different document templates that are referenced in the criteria.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Syntax against vocabulary do you think John?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Well syntax is usually taken as being structure and form, not so much content.

M

Semantic is most likely the vocabularies...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah.

M

...required vocabularies.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yup.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

So what I think he's saying, and I don't know if he's offering opinion or challenge...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

(Indiscernible)

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...but semantic checking would require content validity checking of each document template, you've...I think he's saying it wouldn't work as one-size-fits-all, so you've seen one, you've seen one if you're doing one of the templates. I think one of the templates might have been discharge summary and another template might have been...

M

Right, ADT...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...a form, you couldn't extrapolate one to another, you'd need to check each of them to really do that job at testing.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Well I think too, this kind of gets a little bit, in terms of the concern of how to do this is when you want something to be syntactically valid but the semantics of it actually are not really clinically useful or viable or what was recorded in the EHR...doctor, did not fully get pulled over into the C-CDA, even though the C-CDA is "correct;" it has all the right fields in place.

So running it just through a schematron check maybe won't be fully to get us there, we're going to have to do some kind of evaluation, which is we do it now, but obviously on a smaller scale. I mean we can't...and now...gets into just all the variations of where data can come in and how it'll be recorded and the different types of things, different types of lab results that are recorded. So it meets a, I mean honestly personally I really think this is important for us to do from healthcare, but it's also a very daunting task, just even as an ATL speaking and thinking how we would go about testing this.

Maybe think his fourth bullet point is the idea of maybe only checking it maybe one time, because again as far as the semantic interoperability, different systems like maybe it's a VDT summary versus a transition of care, that data may get entered in or created differently or pulled into the C-CDA, so we probably need to check it on every...every way it goes out, that might be...or at least ask ONC. Is that something how we want to do this for every way the system produces a C-CDA, do we need to do this kind of compliance check for the performance as well? I mean it just gets into it...it's a big task to really do this.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So how does that comment tie into the last bullet? Help me tie the two together, please.

Kyle Meadors – Director of EHR Testing- Drummond Group, Inc.

Well, I think he's saying testing syntax just once...the idea that we can just test the CCA here's just one, you know, or whatever, it matches the gold standard for things.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay.

M

Yeah.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

But, for example, when you create it for the transition of care, you may enter in data or data maybe gets put in the C-CDA that's really looks different, like we're going to lay out all the lab result, instructions get pulled over for that as opposed to the more general summary care that goes up into the portal. So, I think they're just...I think he's trying to say is making sure that it's...the C-CDA gets used in different ways, data portability, transition of care, summary records in VDT; are we...on all of those ways that it goes out, are we verifying that the clinical semantics are accurate and then properly encoded.

M

Yeah, like have they chosen the correct vocabularies for each diagnosis?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well and further, I think he's trying to not judge how, you know, whether or not a given vendor is reusing a lot of capability to create what might be common section level or algorithms or routines for providing particular content and one test is not going to be adequate; you can't extrapolate off of one test to say just because you did the template used for discharge summary correctly, I can't draw any other conclusions.

He might just be simply saying that's an inevitability of the way it's being proposed that to properly validate semantic interoperability you've got to do it for each output, unless you're going to do something else for the vendor to attest to something that says, I u...I reuse my component for producing

a problem list section of any of these outputs, since it's a common component. I don't know if he's arguing for one or the other, but I think he...that's the point he's saying, you've got to test specifically you just can't take it as truth that you've seen one template successfully pass that others necessarily will.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right. Okay. Umm Cris, we've got another slide...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

...CDA...C-CDA.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Let's go to the next one and see if...yeah, I think that's fair and see what conclusions we can draw at the end here. So, his four comments here you can read. I think his proposal is that we...that ONC minimize vagueness by specifying exact requirements for interoperable exchange. And I think the logical conclusion is detail any...the expected option to use for each message. I think these are a continuation of what we were talking about on the previous slide to some degree. It's sort of a damned if you do and damned if you don't kind of problem.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right. It's...forward, that was kind of what I was thinking, you know, sort of like, I think it was Sarah, but it could have been Kyle, I'm not sure; was talking about optional fields and we had this discussion last round when we were trying to get into the C-CDA a little bit that while optional fields certainly allows maybe more usability, it is a nightmare for the vendors trying to provide us with tools that are actually interoperable between the providers. Because like Sarah or somebody said, if you don't complete the optional field or you do, you don't have an exact match; it is what it is. And then...

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right and we've run into problems around, in our discussions previously, around getting the structure right and then within that structure, getting the language right. We're compounding this problem to some degree, or simplifying it, depending on how you look at it, if the industry moves from sort of one-size-fits-all, here's a C-CDA in which you may do multiple things, general purpose tool as opposed to specific profiles of C-CDA which are intended to be more constrained, more consistent and arguably more interoperable.

All right, are there comments about the two second bullets on this slide? We've discussed it before; the idea of ongoing post-certification interoperability testing. This says that in the case of sort of "must have," when we discussed it before it was in the context of mimic what happened in the X-12 world when the HIPAA transaction sets were implemented and test frames existed on an ongoing basis on which vendors could test their transactions to make sure that they could be consumed at the other end.

I think we came to a pretty good conclusion that that approach, the idea of kind of an open test frame without mandate, was a good thing and we got a good response on that in our recommendations that we took to the Standards Committee last week.

On these last bullet...two bullet points, do we continue to have the same consensus that having ongoing, non-mandatory test frames in which vendors and hospitals and providers can test transactions, is a good idea?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

You know, I would think so because it's still and I'm trying to take it into context, too; first couple of bullets there that you're going to need the ability, even if your only need was to affirm that what you were about to do as an implementer or a vendor having reason to do it as well in support of an implementation, wanted to have a vouchsafe opportunity that what you're expecting to produce met the expected outcome that the certification would purport. Let's face it, unless you're going to get very prescriptive in what you do with optionality, which is kind of both an ironic statement and an oxymoron, you're going to want the ability to verify that what you're about to do should pass muster with your trading partner and you can point to independent evidence of that.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation'

Right.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

So that it's minimum value or reason for having that accessible.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So I want to suggest for brief conversation, we've had before the discussion that says, if you put enough of this into production and you have enough of a marketplace for people to exchange data that over time, that'll get to a de facto standard maybe faster than an a priori, highly constricted standard. Cheryl raises the point though that EHR vendors and their customers are not the only players in this space and that you've got HIEs and others who are consuming other kinds of documents that are not necessarily going to be C-CDA.

So, maybe this is too much of a philosophical question, but let me give it a try anyway. Do we want to take an opinion that the best way to get here is for ONC and let's say HL7 to be more prescriptive and create more mandates and less optionality? Or do we want to take a pathway that says, let the market work it out through robust post-implementation test frames? Or do we want to say both or something else entirely different?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Well I think that we need a little bit of both. I think that we need some things to be constrained further, which we had identified.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

But, I also think that we're going to discover more and more use cases and more and more pieces of information that are valuable and pieces of information that are not valuable and so it's going to be a living, breathing process. And to that degree, you need to make sure that you're not locking yourself into something that is going to prevent the flexibility to meet the different business needs for data exchange.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, and this is Kyle, I kind of reading all this section, that phrase, the enemy of better is perfect is coming to mind that I think we really should try to make this better and I do think some constraints and some profiling of some things would be good. But to...if we try to just nail it down super tight, then that's just, we're really not going to get anywhere. I mean, it's much better to be...I know everyone wants to get us there to interoperability perfectly right now, but there are a lot of factors, a lot of players involved and it's just I think we just need to keep making progress more than anything. So, I mean, I would encourage that we kind of like what Sarah mentioned is, I think we need some things honestly we're even being charged by our accreditation group ANSI to be a better job as an ACB for all the ACBs, of checking these kind of things, so we're kind of having to do this anyway. I would like to have some better guidance from the ONC on things to focus on, but at the same time, not make it so constrict and so regulated that chokes out all the other innovation and just things that the market can work on or the market just needs that flexibility to begin with.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Others want to offer opinions before we wrap up this one? I don't know, Liz, I think we're only part way through this one, unfortunately and we may have to come back to this.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

I agree. I don't know, we have 8 minutes...we need to talk about the removal of the meaningful use measurement certification; I don't know if we can squeeze it in or if we need to go to public comment, but that still remains on this section.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'd say if in doubt, let's see if we can squeeze some comments in anyway.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay, so go to slide 14. So my question here was, I guess David and group jumped, or maybe not, that this was strictly CQM measurement, is that what it was intended to be was strictly CQM, not the rest of the MU measures?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

No, this reads as doing away with functional measure certification.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, this has nothing to do with CQMs.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay, what did you say? It is or is not? Is it bigger?

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Is not.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, well that's what I thought, too and that's why I was...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

This doesn't have anything to do with the reporting of clinical quality measures, that's still going to be required...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...as part of a base EHR, at least I think it was the C-1 criteria, but.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

This is really, this is just the change to make, going back to what you said earlier about opening certification to be not just about the Meaningful Use Program, that's really what this rule change is, because they're saying now you can, for example, get certified in CPOE without having to also get certified here to this (g) (1) or (g) (2). Now, to quality for Meaningful Use...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

You have to.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

...rule, you still have to do it, CMS puts that requirement in; but in terms of the ONC...they're trying...it's just going back to the idea of being more agnostic. So in some ways it's more of a regulatory activity than anything.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah.

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, I would agree. I think this one's a sure sounds great if your intent is to use certification criteria that test functionality to support offering chronic care management benefit or enabling appropriate use guidelines to be used for diagnostic image ordering where measurement doesn't matter, you're not...so, there's no reason to oppose this for its applicability. The Meaningful Use Program's still going to require you certify to (g) (2) or (g) (1).

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Right, but it allows you, if you decide that you've had enough of doing this calculation and you want to use like a third-party registry...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yeah, yeah.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...it allows you...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

...even there it's useful.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...have functionality in your product without having to calculate it, where before you couldn't, so, I think that we...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...should support this, because anything that...

John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation

Yup.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...gives more options to everyone is a good thing.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So Sarah or John or whomever, let me as a question then. Is our supposition from this that as a provider, my module, even if I'm reporting for MU does not have to be certified to do measurement?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Oh you have to have...you have to put together on the CHPL in your shopping cart a combination that does include something that will calculate it, but...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Does it have...go ahead.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...you know, so for example, there are a lot of third-party companies out there that are registries...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...and in addition to being registries for quality measures, they also will calculate your meaningful use numerators and denominators. So you could have an EHR that uses, you know, or that does this, but you might want to use the third-party because it might be easier or the EHR vendor might decide to outsource it and just be a module and not include it. So, there are lots of ways that somebody might want to have a modular certification that did not include this calculation, but it is absolutely certain that the end-user, as long as there are meaningful use measures that require calculations of numerators and denominators for thresholds will have to have something that is certified to it.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right. Okay.

Kyle Meadors – Director of EHR Testing – Drummond Group, Inc.

Yeah, it's really...it's a good thing, I mean, it still gives you the coverage without forcing implementations that really aren't designed to do analytics that basically had to do it before.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

And so we think the comments on CQM then that were made by the group?

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

I don't think that this relates to the CQMs at all...

M

Right.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

...because CQMs actually are being reported electronically using QRDA so it's not...they don't fall under this automated numerator and denominator language.

Scott Purnell-Saunders, MSIS – Senior Advisor, Health IT Certification Program – US Department of Health and Human Services

And this is Scott from ONC; that wasn't the intent there, it was not for apply towards clinical quality measures at all, it was just trying to broaden the program, as has been stated to allow...to not limit this to just being a meaningful use requirement so that if other programs wanted to leverage this particular criterion or option, they'd be able to do so and wouldn't feel limited to what the meaningful use requirements were only.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So I would say then, Brett, we would want to rearticulate what has been said here is our understanding and be supportive, if that is...if our understanding is correct, then we're supportive of the change.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Got it.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay. All right.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

...right, Liz.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay. So, I think we are...I think we have to go to open comment at this point.

Sarah Corley, MD, FACP – Chief Medical Officer – NextGen Healthcare Systems

Yeah, I think 3 minutes is being pretty...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

It's about as high as we can get it.

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

Caitlin or Lonnie, can you please open the lines?

Public Comment

Caitlin Chastain – Junior Project Manager – Altarum Institute

If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press *1 at this time.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

And maybe while we're waiting for public comment we can quickly go to kind of the, I forget if it's right before this or maybe right after, the next step slide which shows the different workgroup assignments and the due dates for...

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Yeah, slide 16, is that what you're looking for?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Perfect Brett.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yes. Perfect, right here on the screen. Just to remind folks, it looks like according to what I noted we have maybe just one or two that we can hopefully tack on to our report out on May 8, just so folks have a sense for where they belong and who to contact. And I'll note that we inadvertently left Kyle Meadors off of the slide for group 2, but...he's actually on the first one so, great...questions, feel free to reach out and we can get everyone plugged into where they need to be.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Great.

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

Thank you Brett; and we have no public comment.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Okay, fantastic work everybody. More to come, right?

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

Thanks everyone.