

**HIT Standards Committee
Implementation Workgroup
Transcript
March 21, 2014**

Presentation

Operator

All lines are bridged.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Implementation Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Liz Johnson?

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

Here.

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

Hi, Cris. Anne Castro?

Anne Castro – Chief Design Architect – BlueCross BlueShield of South Carolina

I'm here.

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

Hi, Anne. David Kates?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

I'm here.

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

Gary Wietecha? John Travis? John Derr?

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

Here.

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

Hi, John. Joe Heyman? Kenneth Tarkoff? Kevin Brady? Michael Lincoln? Micky Tripathi? Nancy Orvis? Rob Anthony? Stephen Palmer? Sudha Puvvadi? Tim Morris? Tim Gutshall? Wes Rishel?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Here.

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

Hi, Wes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Hey.

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

And Mike Lipinski from ONC?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Good morning, it's Mike.

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

Hi, Mike. Is Scott Purnell-Saunders on from ONC? Okay, with that, I will turn it back to you Liz and Cris.

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

Great, thank you. This morning we – us, so we have a lot of work to do; I think Cris is going to go over the results from our last meeting and talk about what we want to do with that. And then we'll turn the program over to Wes, who has done a lot of preparatory work to get us ready to go through some really interesting new parts of the 2015 edition that we'll need to stay on course for to get done in an hour and a half. And with that, I'll turn it over to Cris.

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

Real quick Liz and Cris, I'm sorry, I just want to – John Travis isn't able to join today and we had made an exception to let Abby – I'm sorry, Gaby Jewell and Greg Meyer join. So I just wanted to let people know that they're on the call as well.

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

Great, that's perfect. And can – before Cris speaks, can we go ahead and move from the – to the agenda, move forward on the slides, there you go. So you can see the heavy task we have this morning in front of us related to transitions of care and view, download and transmit, you know, two of our favorite subjects in the market today. So with that, I'll have – move to the next slide and turn it over to Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So –

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

Uh, one more –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

– my slides are not advancing here, but I'll just walk through them. So, if you can look at slide 1 that lists our work plan and slide 2, it lists the meetings that are upcoming. We met on the March 13, we're meeting today and then on April 4, 17, 23 and then doing a presentation at the Standards Committee on April 24. On March 13, you can see that we looked at objective, process, and some particular areas that I'll discuss in a minute. Today we're going to be talking about transitions of care and related certification requirements.

If you go to slide 3, which is the summary of our March 13 meeting. We really had the conclusions in two categories, one was broad observations around the nature of this incremental rulemaking and the pros and cons associated with it and whether it would create a burden, even for those who did or did not participate in it. We had a lot of discussion on a phrase that Wes Rishel introduced a couple of years ago around asynchronous transitions of one standard to another, which deals with the issue of forward and backward compatibility. Specifically on CPOE and provider exchange of lab results, you can see our comments here that are mainly questions around whether certification should be pushing adoption of these standards or whether the role is to let the market determine what's best. And questions about whether standards and capabilities separate from MU should use required standards and capabilities.

Our goal in these meetings is going to be to go through the comments relatively quickly. Rather than commenting on it, I'm going to let Wes describe how we want to get feedback and work through the subsequent slides.

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

I think Cris you have one more slide – I think, yesterday did we not have a second slide – no we didn't, I'm sorry, I thought we did. So the other thing that I think Cris and I wanted to share with you is, as he said, he just reviewed for you very quickly the results of last meeting. If you have additional comments or want clarification, if you will email that to Michelle and Mike Lipinski, then they will help us incorporate that into our final document.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Great Liz, and for today, we're obviously going to want to have our conversation be on topics that require conversation. There may be additional comments that you might think of along the way on these regulations that are notes or improvements in language or something that might be a little bit more of a technical improvement of a non-controversial nature. We'll take those comments as well, as follow ups, so that we can focus on the areas that need exploration by conversation.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Actually, this is Mike Lipinski with ONC, I think two other quick points that we had discussed yesterday.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Please.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

The broad observations point, I think we wanted to also save time in the last meeting to talk about any – besides sending those comments on to Michelle and me, wanted to send – maybe save some time for that and also that last meeting for potential consensus on some of the comments of the group.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

Yeah, so – yeah, exa – .comment would be, what is the value of having an incremental edition between MU stages? And we can talk about that more later, but good point Michael.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

We also have a little bit of a housekeeping piece that at the end of the meeting, if we have a few moments before public comment, we'll be looking for a volunteer to – or volunteers, to help us tee up some of the next set of topics. And if we get to that today, that would be great; otherwise, we may do polling by email of committee members.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator for Health Information Technology

And Liz, were you looking for comments on some of the rationale for the 2015 stuff later in the discussion or now?

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

Scott, we'll take those at the last meeting. And – if you want to get them to us ahead of time, that just helps us coalesce what the committee is thinking or what the workgroup is thinking, which I think will help us. I'm – and I think – is a little worried about our last meeting being get everything in so we can take the broad observations with us on April 24.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator for Health Information Technology

Sounds good. Yeah, I'll put them in writing and if we have time to discuss later, I'll bring them up then.

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

That would be great.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Wes, I think we're turning it to you.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay. Well, thank you. I put the – took the items off the slides and put them on a spreadsheet last night and sort of divided them up into easy and hard, and there are 29 items from the slides. And if we kept to the easy and hard, the longest discussion we would have on any one topic is 5 minutes, I think that might be optimistic and as a result, we're going to do two things. One, we're not going to take comments at this point on the questions that are related to 2017, we'll come back to those if by some miracle of the equinox we actually have some time left. And second, I'm going to drive us pretty fast, but if we clearly need more discussion, I'm going to let it happen on a point. As a result, we may have to work with staff to reschedule some of the items towards the end of the list. There are a few topics that seem to come up at several points and I'm going to raise those once in hopes that we can carry that conversation forward. And for Greg and Gaby, the way you get recognized is to speak your name and hope that I hear you and if not, speak your name again at a point and then I'll call on you to make your comments.

So looking at the next slide now, please. All right, that's the first of the topical slides. Issues that come up at several points are the separation of content and transport. Broadly speaking that means that the rule for the format and coding and contents of a C-CDA document or so the thing is not tied to a rule on how to transport. So you should be able to send the same C-CDA, according to the same specs for a C-CDA through Direct or through one of the other forms of transport. I will say that I think this is an obvious and good idea, but I want to offer people a chance to comment on that. Are there any difficulties that arise because of ambiguities in the situations around the different forms of transport? Hearing none –

Gaby Jewell – Senior Strategist – Cerner Corporation

This is Gaby.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Gaby, go ahead.

Gaby Jewell – Senior Strategist – Cerner Corporation

I'm sorry, I guess as a vendor, I would still want a little more direction as to the – constrain the Edge protocols more than what's currently in that implementation guide. It seems a little loose –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So you're okay with the concept of the modularity, but in the actual specifications of the Edge protocols, you feel like there needs to be some more work in order to achieve interoperabil – the ideal situation is that all the systems that are certified interoperate without any custom work. And I'm just understanding you to say we might need a little more work on those protocols, is that correct?

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yes Wes, this is Greg. We've done quite a bit of detailed analysis on that document, a 100%. There's a lot of ambiguities within the document, lots of places where you would expect a "must" there are "should." Lots of different – specificities of the protocols are left too open to achieve a predictable interoperability at the Edge. So there's a lot of tightening up that needs to be done.

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

Can I ask a question Wes? This is Liz.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes.

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

So Greg, when you say that, I guess the intent of the folks writing the rules as – may not have been achieved, but I think what they have tried to do is leave some specificity out to allow decision making in the private sector. And what you're thinking is that actually creates more difficulty from you, it's not helpful. Is that a fair assumption, from your perspective?

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

No, I wouldn't so much say that, I believe we are generally in support of the goal, which is to create standardized Edge protocols to allow providers to potentially select a different HISP vendor to go with their EHRs, so I'm in support of that. The – I believe what the issue is the specifics listed in the implementation guide, the NPRM actually tries to list this as a standard, I wouldn't say it is, it's not even close to that. The problem is that the Edge protocols, the way that you do specific things in the Edge protocols are left so open it would be almost impossible for somebody just to take – to take an EHR and a HISP and just hook it right up, there are just too many details left open that need to be tightened up.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so let me try and interpret this, and I'm not trying to change what you're saying, Greg, I'm trying to understand it; so if I get it wrong, tell me. But one of the changes in the 2015 edition is to change the EHR certification to be one of the Edge protocols whereas before we talked about the inter-HISP protocol, so this is the EHR is now certified for how it would talk to a HISP instead of how one HISP would talk to another. Your concern is that the four methods listed for Edge protocols are not fully specified and based on other conversations we've had, there are specific issues that can be listed. Did I state your concern properly?

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yeah, that's pretty close. Yup.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah. And what I would ask is that you send along to the Chairs and Michelle and Michael Lipinski, any specific information in the form of bullet points that you have. We don't need the full report that you would put into a software support place, but just an enumeration of the issues that you see, so we can look at that and as we come to final consensus, we have some evidence, if you will, to support the notation that you're making.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

(Indiscernible)

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Other people have said the same thing and, by the way, it's worthy of mentioning, everyone who's commenting today has, and in my opinion should take the opportunity to make their comments directly through the process as well. I'm not one of the staffers who has to sort them out. So, we have – I think we have a sense here from a couple of people that in order to have a choice of four Edge protocols so the current documents that are being put forth as standards for that have some ambiguities that need to be resolved. Does anyone disagree with that? Okay, so I'd say staff, we can consider that a consensus of the 20,000 people or so that are on this call this morning.

So, the next issue that comes up multiple times is whether – the issue about replacing comprehensive CDA 1.1 with 2.0. And the concern, I think, that most people have is that two – because this is a voluntary certification program in 2015, two EHRs may each be certified and may not be able to talk to each other. We do know that in the fine print of the rule, an EHR is required to accept and extract data from both 1.1 and 2. It is – so that if a newly certified EHR is receiving a message somehow, whether it's through an HIE, through Direct, through someone downloading and carrying in a document, if accepting it somehow then they're obligated to receive the ones from the 2014 edition certified EHR.

The case that we have not handled at this point is if a 2015 edition EHR chooses to send something to a 2014 edition EHR and it chooses to send release 2, then there's no requirements for the 2014 edition EHR to accept that release, it wasn't certified to accept that release. I think we – I would suggest we need to note that as a significant barrier to adoption of the voluntary standard – the voluntary 2015 edition, and I would suggest that if EHRs in the 2015 edition were required to produce both, at least there's a chance of some interoperability happening. I'm going to put that forward as a trial consensus for us, if people agree, then we'll accept that and move on. Otherwise, we'll look at a process for getting more detailed comments. So how does the group feel about the statement that I made, which I might need to repeat for you. Is it worth accepting that as a consensus and moving on?

Gaby Jewell – Senior Strategist – Cerner Corporation

This is Gaby –

David Kates – Senior Vice President Clinical Strategy – NaviNet

Can you restate that Wes? Its Dave Kates.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Sure, sure. Under the – as it stands now, there is a 2015 edition EHR sending a CDA release 2 document, would not be compatible with a 2014 edition EHR, which was never certified for release 2, it didn't exist.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Gotcha.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

And that if the EHR was require – the 2015 EHR was required to send both, based on some option set in the configuration or something, we could at least work around compatibility issues.

Joseph M. Heyman, MD – Whittier IPA

This is Joe.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes, Joe. Hey, how are you doing?

Joseph M. Heyman, MD – Whittier IPA

– Joe Heyman, hi. I'm totally naïve about this, but my only question would be, how would the 2014 EHR tell the 2015 EHR that it needs to send the 2014 version instead of the 2015 version.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well that's an excellent point and you can no longer claim to be totally naïve about technical issues since you figured that out Joe. The – my thought is it would be worked out in out-of-band agreements between organizations.

Joseph M. Heyman, MD – Whittier IPA

I see. Okay.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

The only alternative is to have them – you get these situations where something goes through an HIE, you don't even know who the recipient is, they – the other alternative would be to require the 2015 edition to send both a 1.1 and a 2.0 and I thought that was a little tough, but, it would be more foolproof.

Joseph M. Heyman, MD – Whittier IPA

Gotcha. Thank you.

Gaby Jewell – Senior Strategist – Cerner Corporation

And this is Gaby.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

Gaby Jewell – Senior Strategist – Cerner Corporation

I just want to say, that's a very excellent point you brought up about the 2014 not being able to accept the 2015. I would contend that even if they sent both, the 2014 still needs to know to look for the one that it recognizes. So it's still not without issue and even the HIEs, right now there's still not a way to even identify a Consolidated CDA from the old HITSP C32 CCDs out there, they still haven't come up with a format code to differentiate them, very slow process. So –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so at this point, according to – I've had different answers to this question from different people, but let me repeat what I think I heard you say, and you can tell me what I – what you actually said. At this point, a document coming by one of these transport mechanisms from another EHR, the receiving EHR has no way to just look at it and say, well this is a C32, I'm going to use the C32 parser or this is a C-CDA 1.1 or this is a C-CDA 2.0. Is that correct? Is that what you're saying?

Gaby Jewell – Senior Strategist – Cerner Corporation

So that's partially correct. As of 2014, we should be able to differentiate between the C32 and the C-CDA 1.1. But if you send us a C-CDA 2.0, we wouldn't know what it is, and we would just ignore it –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, we agree that the 2014 is not expected to recognize a 2.0 and deal with it. So, the only way that this can work is that either people don't put their 2015 approved – optional approved code into production or they have some out-of-band way of specifying when – that the sender must send them the release 1.1 version of the document.

Gaby Jewell – Senior Strategist – Cerner Corporation

Yeah, and I guess I would say – this is Gaby again, I would say that it's more that out-of-band you agree that you're going to send the 2.0.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well, I can't – I don't think you can compel the 2014 edition system to accept 2.0, it was never written to accept it.

Gaby Jewell – Senior Strategist – Cerner Corporation

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right.

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

Wes, if you capture that and then on our – observations, we say – which is exactly what I was thinking as you were going forward, as a person that would be – as a provider that potentially could be compelled to take the 2015 edition, given the – as we continue to compile potential integration problems or interoperability problems, I would tell you, I would not virtualize it. But regardless, we'll capture what – and then Mike, if we can capture under broad observations the secondary thought of whether or not providers making use of – edition would be helpful.

David Kates – Senior Vice President Clinical Strategy – NaviNet

This is Dave Kates; I mean I think maybe restating that we should be explicit about what we expect a behavior of the 2014 compliant system to be on receipt of a 2015 compliant. It could either – gracefully, ignore it like Gaby just described or it could be backward compatible, or there could be some handshaking, but regardless of what technical approach we want to take, that we should be explicit about that required behavior needs to be.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I'm afraid that conceptually we can't go back and create new rules for the 2014 edition EHR.

David Kates – Senior Vice President Clinical Strategy – NaviNet

Fair enough, yeah, so –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So, we can't actually do that. I think what we have, we've noted a very substantial operational issue with regards to the 2015 edition. We, as a group, have not come up with a suggestion on how to deal with it, but we expect that having highlighted this issue, various individual responses to the NPRM may come up with suggestions and it'll be up to ONC, as it always is, to sort through those and find the magic formula. Is everyone acceptable with moving forward at that level of discussion on this topic? Go ahead, no, go ahead.

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

Yeah, I was saying, absolutely.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Wes, I would say yes and it's obviously a topic that will have commonality across a couple of other specifications, and we'll want to summarize that at the end.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah. Calling attention to the screen, we're dealing with a number of issues related to transitions of care – oh, one other thing that comes up several points, and I haven't imagined anything very controversial about it. But that's why we have multiple eyes on this, including UDI as a data item in certain documents and one of the tested data elements for certification, I regard as not being very controversial. Do other people have concerns that I kind of have glossed over here?

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

Well Wes, can I ask a question for clarification?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Sure.

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

Talk about putting a UDI in, potentially obviously from a patient monitoring – the home setting. Does this edition contemplate how that happens or how it's – it's not about putting a field in that could receive it, it's about identifying whether it's a real UDI – do you – I don't want to go into all the details just to understand what I'm saying. I don't think that philosophically there's any controversy, I just don't know, and maybe Gaby or you or Greg would know, is that something that we already have the potential to do? Or is this a whole new level of –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I'll – I will share my level of ignorance with you on this point. As far as I know, the UDI is an accepted standard for implantable devices, so typically a surgeon might record –

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

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– the device identifier of an implantable device. Another requirement, not on our table today, calls for EHRs to be able to accept that and the items on our table today call for them to be able to transmit it in C-DA documents. And whatever the controversy around being able to accept it, under the premise that if they have it, they can transmit it, it's a nice well-formed, identifier and we know how to do that, seems to be acceptable.

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

So what we're saying though is that – so today, we keep track of implantable devices because of FDA recalls and so on, so we do that today.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Um hmm.

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

Where I – that it may be a different place, and it certainly will be in the Meaningful Use standards, is our ability to receive the identifier from home equipment, if this is a different – it's the same concept, but this is a different context, is that what you're saying?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

No, I'm – maybe I have misread this, but my reading was it had only to do with implantable devices. If someone from staff can correct me if I'm wrong, I didn't read anything in the 2015 edition that talked about – they're not even required in home devices at this point, they're only required in implantable devices.

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

So I might be skipping ahead to 2017 and Meaningful Use. Mike, can you help us?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, no, it's just the patient's implantable device – and so it's just the unique identifier from that and it's – so what you're talking about now, it's rolled up into the Consolidated CDA for exchange, for this particular one.

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

Okay, but I –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

There is an actual separate, proposed new certification criterion that you guys will discuss at some point, related to implantable devices.

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

Okay, great. Thank you. I'm good.

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

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, was – John, did you have a question? I thought I heard a question there. I guess not, okay. So I have proposed in the agenda today not to talk about the gap status of each of the items in here. Looking at them, they seemed to derive directly from the content and if we have time at the end and we want to come back, or if people feel we need to discuss the gap status on an item, please interrupt me to say so. But otherwise, I'm not planning to discuss it.

We're now through the preamble and able to talk about the first slide. Moving right along, the first slide has several items related to transitions of care. We've already talked about the general notion of decoupling content and transport wherever it would apply and we – I think we agree that in principle it's a very good idea that in the area of the suitability of the various transports. There are issues that are quite notable and that we're expecting more data, at least from Gaby, with respect to what those issues are. I have had similar comments from Arien Malec in an offline discussion about the specifications as well.

The next topic under this slide is going to Release 2 of the C-CDA. We've already had a general discussion about interoperability issues with multiple editions in play at the same time. Are there any other issues about C-CDA Release 2 that would make one want to comment about its being chosen for transitions of care in the 2015 edition, other than the difficulties in actually interoperating because of the voluntary edition? So nobody has any specific concerns about Release 2 by itself.

Gaby Jewell – Senior Strategist – Cerner Corporation

This is Gaby and I think by itself, I don't. My co – I guess my question back to ONC will be more they've had – S&I Framework's working on long-term care and longitudinal care and what is the assumption that that will roll into the requirement or using Consolidated CDA –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, so can someone from ONC answer that?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

No, we cannot answer that because that wasn't discussed in the Rule –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– anything related to the expectations of that, so.

Gaby Jewell – Senior Strategist – Cerner Corporation

Sure.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so they're – they have – they're required – working for the government, they're required to operate with one hand tied behind their back and a gag around their mouth and they only occasionally get to say something out the side of their mouth, so, we'll – this is the world we live in.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I mean, you've identified work that's being done –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– and so – I mean, you're making I guess maybe logical assumptions or not related to that work and how it will play in. But, clearly we weren't in the position or didn't feel like we were in a position to discuss that work and how it would relate in the rule. So, take that as a consideration as well.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So, just as any work that's going on in the S&I Framework, it's public, people can look at it, they can be thinking about how it would fit into future rules, but ONC can't take a position on that, is that about right?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, in terms of we didn't yet in the rule.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So if we haven't in the rule, we – it would be...it wouldn't be appropriate for me to say after the fact that we planned something or something like that.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right. Yes. Okay. So, now the next item here is a proposed performance standard that, now this is a performance standard, it's not a certification standard, and it is – so it means it's on the end-user during the attestation period rather than on the vendor during certification. And the performance standard is that the EHR should in process, properly formatted C-CDA documents 95% of the time. I'll open the bidding here by saying properly formatted is a pretty loose statement and it would lead to a number of disputes about, well we didn't process it because it wasn't properly formatted and the other person saying, yeah, it was properly formatted. Those disputes can be resolved by a third party, but we don't have a mechanism for doing that. I'm open to other comments about this particular topic, this particular performance standard.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Wes, this is Mike with ONC. I did want to take a step back and say that I do believe that it is going to be a standard to which EHR technology would be certified to; the rule asks on ways – feedback for best ways to attest to that and it is a cited standard.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So the fact that – did I – I misinterpreted the fact that it's a performance standard?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes it's a performance standard that would be part of certification actually.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Does that mean – so that means it's not something that's attested to in – it's not a part of attestation –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, correct.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– it's all done during certification. All right, so trying to imagine how – so I guess the question is, does anybody have comments on how they could measure that in the certification process? They – apparently they could have 100 documents, 5 of which were not properly formatted, something like that. I'm asking people to speak to the possibility that – to the methods by which this could become a viable certification rule.

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

This is Kevin Brady from NIST. I think you're confused. This – once it goes through certification, it's done, and you can't measure anything past that.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well, we have confusion between NIST and ONC, apparently.

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

Yeah, this sounds like a performance standard.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well that's the – the word performance standard in there does tend to be a hint.

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

Right and that has nothing to do with certification, aside that it goes through certification once and then after that, you would have to measure every time whether that was a compliant C-CDA.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, Mike, any thoughts?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Umm, so, it's a performance standard, correct and NIST is – I get what NIST is saying. But if you go to – it's been now – it's in the ToC criterion and also a standard now that we're proposing to codify under I believe it's 20 – I think it's 202 – §170.202 – I need to go to the reg text, so if you can just bear with me for a second –

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

So Kevin, while Mike looks –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, while you guys talk, I will get you the citation.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, when I read this, it sounded to me like you would have to run it through a validator every time you sent a C-CDA, to be able to – as Wes said, I'm sending the C-CDA. If I run it through the validator it says it's good that says I sent a good one, and then if the guy can't receive it, then it's his fault. But there's no way to check that on the fly that I know of.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

Gaby Jewell – Senior Strategist – Cerner Corporation

Well, and it's also incumbent on the receiver to validate it, because I may be able to receive it, but that doesn't mean I can import out of it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Correct.

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

Well I think in terms of measurement though, so work with me on this and see if I'm correct. The way as a provider that we do measurement, unless the specification or the measure specifically says we have to validate on both sides, we only measure on our side, we do not take responsibility for the person on the other side because we may – it may be an external partner on whom we have no authority whatsoever.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right, so it think – validated

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, I think the theory here is that there is an objective way of saying, this document from that third party is – does meet the standard.

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

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

And the flaw in that theory, in my mind is that it is the – there is no agent to do that, that is, if the EHR can process – can't process the document; it's going to believe it's invalidly formatted. And we don't have a referee.

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

Correct.

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

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So I think – I'm going to put forward a draft position that this particular requirement – we don't see a way to measure this. Now, the way – as I understand it, the way the NPRM is worded, they're allowing for this concern by saying could someone suggest a way to measure this. And in fairness to the folks who write the rule, we should have a positive discussion on it and I – balancing that against the clock, I'm going to suggest that if someone right now sees a way to solve this apparent conundrum, please let us know. Otherwise we'll look to people commenting directly on the NPRM to provide a way, and we will state we were not able to find a way as a committee.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So yes, this is Mike and just to confirm where this is at, it's clearly obviously in the transitions of care certification criteria and it points to it being a performance standard under §170.212. And yes, so we have asked, I think you've summarized it well, Wes, that we have asked of how people think that this could be tested for certification. So, we've heard comments already, obviously, as to whether or not that –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So our comment would be –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– it's difficult to understand how a performance standard is tested for certification and then I would – I don't want to be someone who just throws something away because of an erroneous phrasing or something like that. So I do want to sincerely offer people the ability to create a constructive response here, but I'm going to use the substitute Chair's prerogative to move us on to the next topic at this point, hearing no objection.

The next topic is the addition of some data elements for patient matching so that the – I believe it's the header of documents, would have some constraints on certain data fields that would increase the probability that an incoming document could be matched to a patient in the receiving EHR. And there's a list of what those documents are – what those data elements are – personally I found the rule on the birthdate to be quite surprising which is that it must either all be there or none of it must be there. In general, I think operationally my experience, back when I was doing master patient index systems was that having the year of birth but not the month and day was not all that uncommon and useful information in driving matching algorithms. So that it would actually constrain the ability to do a good match if when we knew the year of match and didn't know the month and day, we couldn't send anything; other thoughts from other people.

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

In all candor, Wes, that is also what we do today because – I mean there are other things that we use that for, we don't necessarily get data specific. For example, when we collect advance directives, if the year of birth indicates they're 65 or older, we collect.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Um hmm. Okay.

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

We – but for a measurement purpose.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right. So, I hear one – I believe I interpret that as support for a comment that says the all or nothing approach on birthdate is an unnecessary constraint.

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

That is correct.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

All right, anyone want to agree or disagree.

Gaby Jewell – Senior Strategist – Cerner Corporation

And this is Gaby and we agree.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so I think we have a real consensus here. Another comment there?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I'd agree if you want greater consensus.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, okay. No, I thought I heard someone –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think it's background noise, sorry.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– interjecting, okay. So, the next item is the UDI. I believe we have discussed that and blanket agreed, given our understanding, that it's only about implantable devices. So the next item is shifting incorporation regulation out of ToC section and it's discussed on a later slide, so we'll pick that up on the later slide. And now I think we can move to the next slide. Thank you.

So this is about – this is the very next – the very slide that was referenced in the previous slide and in essence, my interpretation is that there are certification rules that describe what it means to incorporate data from an incoming message or document, into the EHR. And that we've learned a lot through Stage 1 about the reconciliation process associated with that, that the drafters of the 2015 edition would prefer to reorganize the regulation to make that common language rather than repeat it in several different use cases. And I have to confess to having not read that section in detail to see if they added any other content, either intentionally or unintentionally, in the regulation. But I'd be looking for thoughts from the group, either someone who's done that homework or just on the general topic of incorporating – of making the incorporation rules the same for various use cases that are sources of data for the EHR.

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

So Wes, would you ask your question one more time?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay. So first of all I'm counting on Mike to pull me back from the abyss here if I'm really going, I guess I can say off the deep end in the abyss in the same sentence. The – right now, there are rules that say, if you get a structured document or a message, there are certain data elements that must be extracted from that and appear in the chart. And we have learned through experience in Stage 1, that the user interface for that process involves a user, meaning that this doesn't happen in the background, there's a reconciliation process that goes on, so you don't accept every problem or every allergy, you typically compare that. For, I assume, that reason, they have taken the regulatory text that describes that process, moved it out of transitions of care and moved it into a new section, which is about reconciliation. And that what I don't know is whether they added anything in the process, in moving it. But conceptually I personally think that having a section on reconciliation and putting an incorporation rule there makes eminent sense.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So this is Mike from, ONC and well said, Wes, that's pretty much it in a nutshell. We'd, because of workflow design issues that reconciliation is happening almost simultaneously with any type of incorporation. We understand that and have moved incorporation into that other associated capability in certification criterion and we have not added any additional data elements, but we are requesting comments related to additional data elements.

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

Okay.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, does any –

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

Yeah, I just had a couple of questions. Mike today, the reconciliation that I'm most familiar with is medication reconciliation, that's the data that we now take in and incorporate into our record. Can you send us, offline, a – the list of all data elements so I can take a look to see before I can really comment? I know what –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

It's just three; it's just medications, problems and medication allergy list.

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

Okay, all right, so we do that today. Okay.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah. So Mike, I understood your request for additional – comments on additional data – to be part of the 2017 edition –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, so it's not –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

We're skipping over that, right now procedurally, just trying to get through this list.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, those additional data elements is to inform the 2017 edition. For the 2015 edition, just the straight change of moving incorp –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

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

Okay, so we're agreed to come back to 2017 when the 2015 work is finished, right. Okay.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right, so on the 2015 we push the easy button and we move on.

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

Up.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, now the next slide please, is about data portability and the –

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

So we're back to –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– previously discussed things about using C-CDA 2.0, using – including the UDI apply here.

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

Yup.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

And then there's a comment about what to call this, a request for comment about what to call this, suggesting that data portability is a term that could be interpreted in a number of different contexts and the intent of the Policy Committee Interoperability Workgroup was focused. I did talk to a member of the workgroup who suggested that the alternative term data migration suffers from the same issue in that it promises more than initially can probably deliver. A term that apparently they used was portability of the core clinical – of having a core clinical record export and import. And my interpretation is that the core clinical record represents not all the data in the EHR but all the data that fits into the standard artifacts we're using to describe the data that's being ported from one place to another. So –

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

(Indiscernible)

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Go ahead.

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

Yeah, that would be okay if we had a list of what is in the core – you know what I'm saying, I mean, I'm not – I think that's a better description as long as the data elements are clear and it's not a significant change from where we are today.

W

You can –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well I don't – go ahead. Did someone else have – I think I heard another person? Okay. So, I would suggest that for the purpose of today's discussion, we ask staff to get us that list out of the regulation and try to find a time to revisit this another day on the agenda. Does that make sense?

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

Yeah, and what we're really talking about here I think Wes, from your perspective is nomenclature, especially if we agree that the list is rational.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

So the list hasn't changed though from the 2014 edition.

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

Okay.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

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

Okay.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Other than the updated Consolidated CDA and then the UDI, but otherwise, same data elements.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, I understood the discussion here to be semantic –

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

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– about whether using the term data portability or data migration was preferable, and the comment that I am proposing is that each has some difficulties but that core clinical record migration would help to match expectations to – that are created by the title to what we're really expecting to happen.

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

I think that's more descriptive, Wes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so we can record that as a – unless there's an objection, we can record that as a consensus point. Now we're going to move to the next slide and VDT. One more slide. And everyone gets out their – shifts to the lower part of their trifocals and we move forward. So, I expect we're going to be here for a while on this one. So the clarifying text that's covered by some bullet points here, and I – you need to get younger people for this, the clarifying text in essence says the phrase enter a third party destination of their choice does not require the EHR technology to support every possible method a patient could conceivably use. Rather, it means you should be able to enter a Direct – any Direct address. And some people have read that to say you are required to, as an EHR to be able to send to any Direct address, even if you do not have an established trust relationship with the HISP between your HISP and the HISP that is handling the third party message.

And the comment is that not having a trust mechanism leads to – a method of verification of trust leads to potential for misuse of information for false flag receiving of information and loses the due diligence that the user organization that's sending the information expects about the policies – the ability of the receiving organization to care for the information in line with HIPAA requirements and good privacy practice.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

So, Wes –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, go ahead. No, I'm done.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

This is Dave Kates. If I understand your point, the – wouldn't we want to separate the responsibilities for that trust relationship, so, not put it on the EMR to have a knowledge of whether that HISP and the Direct address are in the trust relationship. But instead the EMR rely on the HISP and if the HISP doesn't have a trust relationship with the destination Direct address, then it behave responsibly and not forward it, but not make that an EMR responsibility.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well I think what really is happening here is that the behavior of the HISP is being imputed onto the EHR in the clarifying text.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Wes?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So people are interpreting the clarifying text to say, if there is a Direct address, and what makes it valid is that there's a certificate for it available somewhere, you're obligated to use the HISP that will forward it.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yeah and Wes, this is Greg. I've had this exact same conversation and it's – I think the – if I remember correctly, the specific text in the NPRM is something li – instead of it is unacceptable to limit in ways to send, I think it may actually specify it is unacceptable for the transport to limit, which is really what mucks it up –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

– in my mind. Because it's not that the EHR shouldn't limit Direct addresses, I think that's absolutely, positively needs to be in there that they can type in any Direct address that needs to be in there. But to expect that the transport, which incorporates the security and trust, there's the big word trust in there, cannot guarantee that it's going to be able to get it out. And in my opinion, that entire sentence just flat out shouldn't even be in there.

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

Well Greg – let me ask you from a provider's perspective, so I'm sure I'm understanding you. So as a person who has a provider send documents –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Liz, we're getting a lot of noise on your channel.

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

Is that – ?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Hello?

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

Is that better?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Oh yes.

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

Okay, so, are you implying that as a provider who sends these documents daily, through a HISP to a known, trusted, Direct email, that I should be the patient – I'm trying to follow your logic. My worry, so I will skip to the bottom is if we don't have a trusted email a Direct email to send it to, how do we get covered in terms of if it's illegitimate. I understand you're saying where does...I think you're saying, where does the responsibility lie, is that correct? Because we're talking about EHRs as objects, which they are, but you're also talking about somebody who owns that EHR and their responsibility.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yeah, so that actually gets down later on in the NPRM, so –

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

Okay.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

– and I had this conversation with some folks at ONC specifically about this because we – we're still going to – I think the intent, at least what I've heard from ONC is that the intent was only allow them to provide any Direct address, but that if that trust relationship wasn't there, the HISPs still could stop the message going through. But later on there is the requirement that a notification or some type of success or failure needs to be known.

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

And where would that notification go? To the sender?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

According to the NPRM, it just has to be recorded and audited. I think in practicality that notification does need to go back to the sender. There are best practices in place in certain implementations of Direct to go do that, although the applicability statement makes no indication as to what is required to do. I would say that if there – if failure notification should be audited, it's probably reasonable to expect that that would go back to the end user as well. And actually, I need to clarify that probably failure at minimum needs to go back to the end user. If you send a success notification back to the user on every message, that's going to clutter up workflow.

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

Oh no. Oh, yeah, no, no, we would like to assume that it went unless we're notified otherwise.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yeah, and that's basically the exact same philosophy that the Direct Project Workgroup – referenced implementation has taken, that it's a best effort, it's assumed that it got there unless you're notified otherwise.

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

And –

Joseph M. Heyman, MD – Whittier IPA

This is Joe; can I just ask a question? If a particular EMR vendor creates their own HISP, can they require that all Direct messages from their EMR have to go through their HISP, that they can now charge money for?

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

So that's a great question. That's where the separation of content from transport comes into play. The capability or the requirement is that the EHRs are capable to be swapped out with any HISP, although I don't believe there's any regulatory thing that says that they have to allow that. So, I believe that EHRs can still require as part of their sales bundling, a line item, whatever you want to call it, to still require to use their HISP, although they would be capable to use another HISP.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Mike, as I understand, the 2015 edition certifies EHRs for – it proposes to certify EHRs for standards for the EDGE protocol. There are some issues about those standards, but, does the regulation – first of all, is what I said correct?

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, okay, so this is Mike with ONC. I think that was Greg that spoke previously –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yes.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

– that – I think that's a fair assessment what Greg said in terms of we are saying that they could work with any HISP, once their certified to – assuming the EDGE protocol is addressed. I know other concerns have been made about that and this gets somewhat more technical than I am capable of providing good feedback on, related to the EDGE protocol. But, yeah, the concept is there as to what Greg said is that the EHR should be able then to connect to any HISP.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So –

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

But the contracts would – I mean it would come down to the contracting negotiating between a vendor and a provider. If I was going to buy that vendors product, the vendor could put something in like that and then you would negotiate as to whether you agree that I'm only going to use your HISP or say no, I want the option to use multiple options – multiple HISPs.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So –

Joseph M. Heyman, MD – Whittier IPA

The problem is that –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– go ahead.

Joseph M. Heyman, MD – Whittier IPA

– there are thousands and thousands of people who are already using that vendor and now they're creating a HISP and the question I have is, for people for example in my community, where we have an HIE. And we're willing to give them the Direct address and we are willing to connect to the state HIE for them, are they going to be forced into the vendor's HISP and take the vendor's Direct address and pay the vendor?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So, I want to sort out several areas of discussion, all of which are germane to the topic. One is a proposal to certify an EHR so that it could, with the shipping product, the product that's covered by their certification, be able to interface to any HISP. That is a technological capability that doesn't imply a business willingness to do that. Okay. However, absent that technological capability, you have no ability – no way to influence a vendor to work with multiple HISPs. The second issue is what possible levers are there to ensure that vendors will work with multiple HISPs. That's not a standards issue, I don't think, I think the standards issue is to assure they could work with multiple HISPs.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

And Wes, this is Greg. You hit right on a lot of the concerns with some of the other folks I spoke to with the NPRM was, does having the concerns that ONC is forcing that EHR technology have a specific business model and that's – although it seems that that might be the case, that's not actually true. They're – I said, you hit it right on, they are enabling hit, but they are not enforcing any type of business models.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right. And then the third issue is sort of the difference between – I'm forgetting, what's the term Internet equality or something. They have created a mechanism, which needs some work, but a mechanism for HISP equality. They have not necessarily specified either an economic or regulatory process to ensure HISP equality and in addition, they seem to have hit upon an unintended consequence, which is that the approach to HISP equality would remove the ability to discriminate on HISPs based on a common agreement on what makes a trustable HISP.

We know that DirectTrust.org is one organization, one dot org that is working on creating those lists. We know that some states have decided not to participate in DirectTrust.org, but to set up trust based on whether the state says it's okay. And we don't know that there isn't some other method. But we do feel – I think – I feel and I think most of the group feels that any regulation that forces a user to deal with a HISP that will send a message to any other HISP, whether or not it has been able to do due diligence in assuring that the HISP is trustworthy, is a step too far.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Wes, this is Cris. I would completely agree and I think the phrase you were looking for from the Internet world is net neutrality.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

That's it net neutrality.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And the proponents for that pro and con are essentially arguing for different economic models around pass-throughs and tolls. I think Joe's comments are correct and it is unfortunate that there are some economics that are troublesome but trying to regulate to better economics on this particular issue I think is going to be difficult. Mayo happens to be members of DirectTrust.org; it's a pretty broad acceptance at this point. It's not going to be the only game in town, there's still Federal Bridge and other kinds of entities that can do certification. But this is one that the market – the markets are good at working out these kinds of problems and regulations are less good at working out these kinds of problems.

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

Yeah, we're doing the health trust thing, too – Cris, are you suggesting that we take the proprietary piece out of it?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think that's the correct approach.

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

Yeah.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I'm not sure what it means to say take the proprietary piece out of it.

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

Well making sure that we don't do what Joe is talking about, that we don't put people – this is going to be said much more simply than probably a more eloquent way to say it, but we don't put people in boxes where they have to buy the HISP from the vendor, that they have open choices.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I don't agree with that.

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

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I don't think we can regulate that the vendor must provide choices.

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

No, I was talking about the provider had choices, I'm sorry I must have misspoke.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah, yeah. No, no, no, you didn't misspeak it – well, I think you said it right Liz. I think the issue is requiring a vendor to –

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

Oh, interface with.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

– have to interface, as described, I think is problematic. I think that they need to be able to certify that there's trust and then there's trust – the kind of trust fabric goes beyond the EHR, almost immediately –

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

Yup.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

– and at the moment, it's kind of a patchwork trust quilt and we're going to want to see the industry move to more of a blanket trust framework. It's not quite there yet, but it sure is morphing that way very fast.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well I'm not clear on it morphing that fast. I hear about state legislatures that are writing requirements that say, all traffic has to go through the state designated HISP.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I live in one of those states.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so I – but I think that we have – we recognize that in principle the notion that there is a standard EDGE protocol that the vendors must certify to is helpful. In practice we may have some difficulty with the standards as currently stated, but in principle, we recognize that's helpful.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And the –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

It's not a solution, but it would be a part of any solution.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

And Wes, can I, in 30 seconds, take that one step further?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Sure.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

So I've come to the opinion that as part of allowing the EDGE protocols to be universal, that's great. But in the long term, that's going to – when a provider comes time to actually do their implementations, EDGE protocol's going to be the least of their worries. There's the whole provisioning process between EHRs and HISPs that's been completely left wide open and it's an ugly and messy process at best. There's no type of standardizations around trying to automate that, facilitate that, create standards around API. Maybe something worth ONC looking at, if they really want to get interoperability working at that level and make them universal, the entire operations process needs to be taken in consideration, EDGE protocol's just one small part of that.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay. So I would modify what I said, maybe reverse it of EDGE protocol is a small part of getting to HISP neutrality.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

And that – so we can adopt one of two positions. One is that it's such a small part that it's not worth the effort of doing standard EDGE protocols in the 2015 edition, absent a broader look at the operation issues. Or we could adopt the position that it's a good idea, subject to discussions about the specifics of the EDGE protocols. Does anybody have a sense of which way we might want to go on that – or, we can just not comment on this, that is, we're not obligated to respond to every issue.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yeah, this is Greg; I would probably go with the second one. Folks are already doing this anyway, so the – there are a lot of folks that are using the same EDGE protocols today and the – so the issues around the operational side still exist, so I still think it's a good direction to take, to push that. But just with the notes that it may be worth looking at in further editions to try to work on some of the other areas. But, I would not –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

So we would note that if we can work out the specific issues on the EDGE protocols, then we would recommend certifying EHRs on the EDGE protocols, recognizing that that's only one of a number of steps that we'll require to get to practical EDGE neutrality – HISP neutrality.

M

Yup.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yup, that sounds great.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right. Okay, then the second issue is I would propose that we take a position that under no circumstances should a user organization be required to send a Direct notion to a valid Direct address where they don't have a means of trusting that Direct address that's acceptable to them under HIPAA.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

And Wes, if I could reach through my phone and hug you, I would.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Oh, how nice.

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

Yeah, I would be in absolute favor, that's my concern is that we cannot be put in that position so what you describe is what we have to have.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay. So, I'm proposing that that statement be captured, this is a good time for anyone who disagrees to speak up, Joe may, in fact, be the ideal person to represent that point of view.

Joseph M. Heyman, MD – Whittier IPA

This is Joe, I guess what I'm – my problem is, I'm not quite sure I understand what you said it was long.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, so let me try to shorten it up. One, certification for EDGE protocols is good.

Joseph M. Heyman, MD – Whittier IPA

Right, I got that one.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay. Two, certification for EDGE protocols won't make HISP neutrality happen, there's a lot more work that has to be done.

Joseph M. Heyman, MD – Whittier IPA

Okay.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Okay, and three, right now there are – the market outside of government agencies, has created at least one mechanism by which a HISP knows that another HISP is trustworthy –

Joseph M. Heyman, MD – Whittier IPA

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– and avoids the concerns that, well, they're just sloppy, they don't fire employees who browse through records. They don't have an anti-virus scheme, whatever the –

Joseph M. Heyman, MD – Whittier IPA

Got it.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

– issue is, all right, and we should never force a user to send or receive a message from an organization that they don't trust –

Joseph M. Heyman, MD – Whittier IPA

That's absolutely fine.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Right, yeah, okay. All right, if Mikey likes it, then I think we've got it.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

I've captured all three points.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Hugs all around.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And Liz –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I'm sorry.

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

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sorry, this is Cris, I'm just looking at the time and I think we're just about necessary to go to public comment and I wondered if we –

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

Yes.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

– how we wanted to handle the last remaining item?

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

I would suggest we open the next meeting with it, unless there's some other way to do it. I just – I don't know – I'm willing to try and do it by email, I just know that people are real busy in the meantime.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Mike, I would say that's what we had intended at the beginning. We knew that sometimes these – we wouldn't – especially this particular one, we wanted to get this one going first, because we knew that there was a chance that we weren't going to get through it all, and this would help us manage our time for the other few meetings. So we could just make these the first couple of topics of the next meeting and I think that'll work out since you'll be summarizing – we'll be summarizing what came out of this meeting.

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

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So I would also say then if we – if people could look at the materials that were sent out in advance, or maybe we could even move the slides back to slide #2 that lists what the agenda is for April 4 – interested in facilitating the conversation on April 4. If you could email Liz and I and Michelle, that would be wonderful. Or if someone wants to raise their hand right now –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well I'm willing to be the facilitator for the stuff I've already prepared.

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

That works.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

The question is if we move on, I'd like to have an understanding of what we're moving on to and either offer another chan – another person the opportunity or make a separate assessment of whether I've got the time.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Wes, had you previously already signed up for the items that are listed under April 4, I'm sorry, I've –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

No, no, no, but we have items that are listed under March 21 now that are going to slip to April 4.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

And I'm prepared to do those –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Please do. Sorry, I –

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Yeah, all right. I would be happy to consider April 4, but I wouldn't want to, by any means deny anyone else their chance to a walk on the red carpet here.

Joseph M. Heyman, MD – Whittier IPA

You do it so well though, Wes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Well you know it's that slit-side dress that really –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Oh gosh –

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

Oh boy.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I think I actually stunned Cris. All right, so do we need to give it to Michelle now to get public comments?

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

Yes, but I will – it would be great if somebody could volunteer soon so that we have time to prepare and Liz and Cris have – we've burdened them with quite a bit, so it would be great if other workgroup members could volunteer their time.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, and it's before – I agree totally with Michelle, we don't have any volunteers yet for April 4 and it's just four public health criterion where you're seeing just some upgrades in the standards, it's the same stand – well, one isn't, syndromic, but there's that, there's family health history where you're moving – where we propose to move just the pedigree. And then you have something – you have electronic notes where we're asking some questions related to search capabilities and we're proposing an enhanced search capability.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

And there are some things that were originally on the list for today that got moved, like open notes, so I assume that will be...

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, well, yeah, open notes I think was a 2017 edition.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

Oh, that's right, okay, right.

Michael Lipinski, JD – Policy Analyst – Office of the National Coordinator for Health Information Technology

We did 90 minutes next meeting, too, so you should be able to get through Wes' wrap up and few criteria and all this.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated

I – again, I would love it if someone who had particular experience with public health took that on, but I'll be a fallback, just let me know that I've been fallen back upon.

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

So this is Michelle, we'll follow up with Cris and Liz, maybe there's somebody in the group that we could identify that could be a great person to review this. And we might just assign it to them, so, just heads up.

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

Right.

Public Comment

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

So with that, we'll open it up to public comment.

Rebecca Armendariz – Project Coordinator, Altarum Institute

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

David Tao, MS, DSc – Technical Advisor - ICSA Labs

Thanks. This is David Tao from ICSA Labs. There was a question earlier in the call about the extent to which the S&I Framework longitudinal care coordination work had been reflected in this NPRM. As one who was active in that initiative, I can say that most of it is not directly mentioned in the NPRM. It doesn't propose the new care plan document, which is the main embodiment of LCC work. But by endorsing C-CDA 2.0, which contains those care plan templates, ONC indirectly may have facilitated LCC work being incorporated in the future. The Policy Committee did not propose structured care plans for MU3; they only suggested adding a few care plan fields to summary documents. But I think it's important to realize the care plan that LCC proposed is not a summary document, like a CCD or a discharge summary, rather it's a forward-looking document dedicated specifically to care planning, it's not a summary of the care that was already given. Thank you.

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

Thank you everyone, have a great weekend.

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

Thank you – to Wes, thanks much.