

**HIT Standards Committee
Implementation Workgroup
Transcript
April 23, 2014**

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – 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 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

Cris Ross?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

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

Hi, David. Gary Wietecha? John Travis?

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Here.

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

Hi, John. John Derr? Joe Heyman? Kenneth Tarkoff? Kevin Brady?

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

Here.

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

Hi, Kevin. Michael Lincoln?

Michael J. Lincoln, MD, FACMI – Director, General Standards – Veterans Health Administration

Here.

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

Hi, Michael. 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

Here.

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

Hi, Wes. And from ONC, do we have Mike Lipinski?

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

Hi, Mike Lipinski.

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

Hi, Mike. And Lauren Wu?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

I'm here.

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

And Scott Purnell-Saunders?

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

I'm here as well.

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

Anyone else from ONC on the line?

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Kim Wilson.

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

Hi, Kim.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention
Hi.

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

And with that, I'll 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. What we're going to do today, folks, is we're going to – and thank you Mike and Cris and all for getting – we've gotten – we've made a serious attempt at collecting all of the comments and preparing the deck for presentation tomorrow. And this is where we are looking very forward to getting the input from the workgroup as to whether we've represented the comments correctly and if they're complete. We will have to – we just have an hour, and once we're completed with the process, we will have to get the deck out to the other Standards Committee members for their review in advance. So that's the work that we have in front of us, it's amazing, I think we'll be very pleased with the amount of work we've gotten done. It's been very productive meetings for all of us. And Cris, other comments?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

None whatsoever, let's walk through the materials.

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

Okay. So, I am sorry, I'm in an airport so I do not have the deck in front of me. I'm assuming that we're on the purpose slide and that we now are going to go to the subject matter and deadline slide. And what the intent is of this slide, and then there's one more, is just simply to ground the committee in what the work was that was assigned to us, to look at the certification criteria, to understand when the deadline was and then how we would be submitting the information. Next slide, please.

And then just sort of looking at, again, overall what we were doing, this incremental rulemaking that we're looking for alignment from the certification group. We had the opportunity, if we had time, which we did not, to look at 2017 and we will do that next. And then we'll move from that slide to the actual meeting times and what we looked at. And what Mike did, and so I'd like to spend just a moment here on slide 3, is we tried to distinguish where we had general agreement and where there was discussion and then you'll see further information around the discussion items. So, we did a check back against the list that we had, and again, we – dates here. There are also dates on the slides which will be – tomorrow, to help us go back to previous comments, and that's what we were doing yesterday was going back and re-looking at the presentations and the comments to try and make sure we moved everything forward. So that covers slides 3 and 4.

We will point out to you that we had hoped to be able to discuss further today some of the final pieces of the certification edition and we just put some comments at the back that we picked up along the way. And certainly, we would be acknowledging with the committee that we did not spend a full workgroup, and again, welcome your comments if you want to provide them to us now or during the Standards Committee tomorrow. And we'll move to the comment slide, and then we'll start in a little bit. So – and we'll be on slide 6 and Cris and Mike certainly would want you to jump in here as well.

The first one we talked about was there was a suggestion that we break apart CPOE into the three categories, meds, lab and rad. And we were in general agreement with that. And so I'll pause for a moment to say, Mike or Cris, any other comment or any workgroup member that does not agree with that position?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think this represented the comments we had.

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

Right. Okay. And then we moved on to the next one, which was really about bringing in LOI and LRI standards and the comments are here for you to review; concern about the fact that we weren't using them. Concern about the fact of whether we should make this move through an edition or should we let the market push itself. And then finally, would it be better to have even a voluntary certification. So again, open it up to Cris, Mike and the group to say, are we missing something? Does this represent the expressions that we heard in that first meeting?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So, this is Cris. I'm just looking ahead in the deck here a little bit. I think we had earlier on said we would try to surface early in the conversation some of the overriding issues and one of them, for example, we'll get to on the next slide around synchron –

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

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

The question in my mind, I think this deck is fine, but I think as we go through this tomorrow, Liz, we're probably going to want to pull up the issues that we think are some of those overriding kind of showstopper – not showstopper, but worthy of full attention from the full Standards Committee.

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

Okay, so if we went to, and I don't know if we can skip forward Cris or – if you go to 21, we have some –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

– of the overall and we might want to move that directly behind and go with that first, is that what we're thinking?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well my guess is these are in the order – the numerical order of the regulation.

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

They are.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Which is fine?

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

Actually, they're just in the order of the way – just for this meeting, particularly; they're in the order in way that you guys discussed them, that is, by meeting.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

Because of – so, it was just for easy reference for folks. But, I can put them back – I'll order them however you think is – you want to order them for tomorrow.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think they're – Mike, I don't want to cause problems, I think they're ordered fine here, I just think we want to make sure we wave a flag on the issues that we think are of significant importance.

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

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And I'm assuming that Wes is going to have some things to say around the items we raised on March 21, I really hope he will.

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

Me, too.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But I don't think there's anything on this March 13 slide, I think that's the main thing I wanted to get across.

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

Right. Okay, and again, so I'm going to pause for a second just to make sure there's no one else on the workgroup that thinks we missed something on this – from March 13 and then we'll move to ToC. Okay, let's go to the next one, and like Cris iterated, we certainly want – this was a very healthy conversation around ToC and asynchronous and whatever your, Wes your term for backwards compatibility is and did we capture that here?

Wes Rishel – Independent Consultant

Umm, yes, I think so. Relevant – subject to the level of brevity that's required by this format, I think so, yeah.

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

I mean Wes, if there is something else that you want to submit along with this, feel free to send that and we will include that in the submission.

Wes Rishel – Independent Consultant

Okay, well, let me – I won't be able to do that by tomorrow, so –

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

That's fine, too.

Wes Rishel – Independent Consultant

Yeah.

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

I mean you obviously can submit comments on your own as well.

Wes Rishel – Independent Consultant

That's what I was thinking is maybe I'll just reference the committee's comments in my comments and then add them.

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

I just was going to say on that point, for ToC, I know someone brought up the idea that the EDGE protocol was not constrained enough. But whoever that was, either for tomorrow or in their comments, if they can get more specific as to how it's not constrained enough that would be extremely helpful to us, in terms of a comment.

Wes Rishel – Independent Consultant

Yeah, John Travis, that might have been David McCallie, you might want to check with him.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Okay, yeah, I can do that Wes, or see if that may have come from Greg Meyer, see if we can get more specifics around that.

Wes Rishel – Independent Consultant

Yeah, no, I think our goal is – we recognize – well, let's not go into detail and let's keep moving.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Wes, this is Cris, could you – what is the phrase that you've been using to describe this problem, it's asynchronous by –

Wes Rishel – Independent Consultant

Oh, you know, I keep forgetting – asynchronous – well, it depends on the problem. If you're talking about the EDGE protocol –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No, version management.

Wes Rishel – Independent Consultant

It's the requirement for asynchronous upgrades of protocols, so –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

It would be helpful to me if we could just use the phrase somewhere on here, changing –

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

Right.

Wes Rishel – Independent Consultant

Yeah.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

– it to say –

Wes Rishel – Independent Consultant

Well, I will, today I will send you, go back to my old notes and send you the phrase and some citations for it and we can –

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

Yeah, it's something around asynchronous backwards compatibility it's something around that.

Wes Rishel – Independent Consultant

Right. Yeah.

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

Right, okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

We should all get our mouths around that phrase and be able to –

Wes Rishel – Independent Consultant

It obviously – I didn't do a good job of creating a memorable phrase, unfortunately, thus failing as a pundit. But, we'll – I think it's better to live with what I said before than try to come up with a new phrase at this point.

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

Agree.

Wes Rishel – Independent Consultant

So my screen just went – I lost the slide altogether, is everybody else having that problem or is that just me?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Just you, it's a California thing.

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

Just hit refresh Wes, and it should come back, hopefully.

Wes Rishel – Independent Consultant

Oh, it just came back. Okay, thanks.

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

Okay. Any other comments on ToC or Cris any clarifications.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No.

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

Wes? Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

No, I just want to get to that issue.

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

Okay, and then on clinical information reconciliation and incorporation, I think that there wasn't a – we didn't document any particular concerns, that we were okay with moving this criterion and thought it made sense from a workflow perspective. And I'll finish the slide and then we'll go back. We did make a recommendation on the data portability to call it "core clinical data migration." Again, recognize that these are not meant to be consolidated comments, these are meant to reflect all the comments that we got. So, given that, is everybody okay with the comments that are documented here under data portability?

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

I mean Liz, I totally agree with you, but I mean where you guys can point out that this is consensus from a workgroup, that's important.

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

Oh, absolutely.

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

Because you guys will all be able to submit your separate comments as well, but where you can show that providers, vendors and everybody agree on a point, that's great.

Wes Rishel – Independent Consultant

Is there anything we've discussed on this slide that we don't think represents a consensus of members of the –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

(Indiscernible)

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

Not to my knowledge, other than if we, what we call something, but I think this shows consensus.

Wes Rishel – Independent Consultant

So let's work under the assumption and note anything where we feel like we are recording individual comments rather than a consensus.

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

Sounds good.

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

Good.

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

Let's move on to slide 8 then, this is on view, download and transmit. And again, here we have the EDGE protocol discussion again and favoring it once, the constraint issues are resolved. This was an interesting one –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

– that Mike and I talked about yesterday and I think Cris and I changed from – should not have to send or receive health information from any Direct address without an established trust relationship, should not require establishment of the relationships. To me, when I read it, kind of in retrospect, it felt like it was – the two statements almost were in conflict with each other, and that's what we're saying is, we shouldn't clarify it because you're saying you shouldn't send without trust, but the certification shouldn't require trust. Is somebody else reading it differently than I am?

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

Shouldn't require the establishment of trust relationships. So, if – this is where I was even confused when looking back at our notes and actually talking with a couple of other folks that took notes. I get the point where – if the point of the workgroup is where you're using third parties, either an HISP, HIE that – I think the goal of the proposal was just to say that the EHR technology shouldn't have any limiting technology, in terms of being able to send to a Direct address.

Wes Rishel – Independent Consultant

Well, let – let's put the issue, the underlying issue on the table and see how it works back towards comments. The underlying issue is that there are either two or n+1 for some n, different efforts to create families of HISPs that trust one another.

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

Okay.

Wes Rishel – Independent Consultant

Okay, one is DirectTrust.org and the other is establishments made by various states. And the cost to a HISP of entering DirectTrust.org involves some third-party certification by EHNAC and often requires some changes in procedure for security and things like that. The major players and this, I'm expressing my own opinion here, but I am on the board of an HIE, so, the major players of – that provide HISPs as part of their services like Surescripts and some of the EHR vendors, have not found that burdensome, but small HIEs have. And small HIEs are often state-funded and are being told that their funding depends on their using the state's method for determining trust.

And as a result, we're in a situation where in a given state, it's possible that some – we can have two HISPs, for example, one an HIE and one an EHR vendor, each certified with a trust organization, but with no mutual trust. And the concern is that the regulations seem to be saying that the – either the EHR vendor has to be certified with all of those or that it – and it's recognized that it can't be certified unless it is certified with one and that one has a trust relationship with the certifying body. So I don't see these as being inconsistent, I see them as two symptoms of a bigger underlying problem.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So Wes, this is Cris. I completely agree with all of that – possible to conclude that with a statement that says that there's no disagreement that these trust relationships exist, it's the mandatory requirement under certification that's the problem.

Wes Rishel – Independent Consultant

Well, the first of the red sentences, which in the first sentence of the second bullet says –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Well I guess you –

Wes Rishel – Independent Consultant

“ – should not be required to have to – ”that's probably redundant, “should not be required to send or receive health information from any Direct address without an established trust relationship.” I think that statement by itself is such a clear principle that it's – any wording in the language – in the NPRM that might be interpreted differently clearly needs to be examined and revised.

Now “certification should not require the establishment of these trust relationships,” that statement, I think, has – my original interpretation of it was that none of the proposed trusting organizations should be specifically required for certification.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Wes, this is John, I agree with you. It should be – I liken it to certification for transitions of care in 2014 where we had to prove some ability to establish trust and know the difference between a trusted address and one that's not. If you build upon that to simply say, if you wanted to say anything here, it would be its fine to prove a capability to be able to establish trust, but don't prescribe the particular, what's the word, protocol, nature, type.

Wes Rishel – Independent Consultant

Yeah, well John, I think the issue that comes to mind is how does one do the mechanics of certifying interoperation under Direct, unless the certifying body has an HISP that is trusted by the HISP being used by the EHR vendor.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, I think that's right. What was done in 2014 was more or less a mock of establishing that trust, based on certifi – exchange of trust anchors and then validating the veracity of the certificates of the trading partners and doing different tests of that kind.

Wes Rishel – Independent Consultant

Yeah.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

And then – that was built on the Direct protocol.

Wes Rishel – Independent Consultant

John, just a question about that. Wha – under that approach, would it then be possible to test the actual exchange of content using Direct between a server operated by the testing body and a server operated by the EHR?

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

That was, more or less, what was done because what you progress to then, you had to do that first to prove your system could understand a trusted – a concept of a trusted recipient to exchange with. Then we actually did use the trust anchor that was exchanged to submit say the transitions of care summary for conformance testing.

Wes Rishel – Independent Consultant

Yeah. So I would say – I would propose revising the second sentence to say, certification should be – should follow the approach used for, and John, you provide the right words, 2014 – blah, blah, blah.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

For the 2014 certification of the transitions of care summary transmission, it was part of (b) (2), well, (b) (1 and 2).

Wes Rishel – Independent Consultant

Okay. Yeah.

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

So can I suggest then if we do that, separate the two sentences so that as we're getting it back, we – they go together, but don't have them – have it be an (a) and a (b) please. Because I'm thinking –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Ah.

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

– are you saying in essence that you are not proving the establishment of trust relationships, you're putting the capability to establish a relationship.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Cor – yes.

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

Okay.

Wes Rishel – Independent Consultant

Right.

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

Because –

Wes Rishel – Independent Consultant

Furthermore, you're doing it sort of on an interim test basis for the purpose of testing.

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

Right.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Yup.

Wes Rishel – Independent Consultant

Because you have to go ahead and – otherwise you can't – it's clear.

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

Right. Okay.

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

So do you want – instead of comparison to ToC in the 2014 edition, are you saying that the 2014 edition VDT, where we didn't decouple transport, is the appropriate way to go for this one?

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

I think what we're saying, Mike, is that conceptually the way of testing – having the EHR have to prove it can establish trust is the thing.

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

Right.

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

Okay.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

And not elaborating –

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

And that's the simplest way to – yeah.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

– to say it's got to be by a given method. It has to follow –

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

Right. That would be my recommendation.

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

Because I guess, what I was thinking is the way it was certified before, you were certified to be able to do Direct, so clearly then, you'd be able to send.

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

Right, but if we keep it simple rather than taking – I'm suggesting to the group, in lieu of going back to a previous certification, if we simply said, you need to be able to prove the capability to establish trust relationships during testing, is that –

Wes Rishel – Independent Consultant

Yeah, during testing for the purpose of testing.

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

Yeah.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

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

Okay.

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

That way we're not going back to – it'll be simpler to explain, I think.

Wes Rishel – Independent Consultant

Yup.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

And at this level, you don't need to prescribe a testing methodology, that's up to the test procedure developer, really.

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

Right. So Mike, have you got it?

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

So it seems to me then that the concern here is for testing and certification purposes, there's the assumption that you would have to prove the capability, of the EHR that is, to establish a trust relationship, which you don't think, is appropriate. Is that correct?

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

No. We're saying if they only have to do the capability, they don't actually establish it, because what this says is, you establish a trust relationship. We're simply saying you test that you could.

Wes Rishel – Independent Consultant

Well I think –

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

Right? Wrong?

Wes Rishel – Independent Consultant

We're back to separating the first two – the two sentences.

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

Right.

Wes Rishel – Independent Consultant

So a –

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

I just want to go back to the proposal itself –

Wes Rishel – Independent Consultant

A certified EHR should not be required to send or receive health information from any Direct without established trust relationship in production.

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

Right.

Wes Rishel – Independent Consultant

And then during testing, the sentence that Liz proposed.

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

Right.

Wes Rishel – Independent Consultant

During certification testing.

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

Correct. And so it's prove the capability to establish a trust relationship during testing for the purpose of testing.

Wes Rishel – Independent Consultant

Right.

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

I'm totally confused as to why you think that would be part of the process.

Wes Rishel – Independent Consultant

Why what would be part of the process?

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

That there would have any – there would be a need to sort of to pass certification that you would have to show that you could establish a trust relationship.

Wes Rishel – Independent Consultant

How else can – ?

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

Yeah.

Wes Rishel – Independent Consultant

The mechanics of how it works – establishing a trust relationship is a two-part process. One involves –

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

Right, no, I'm not saying that to actually do it you wouldn't have to do that, but I'm just saying, all we're saying is that the EHR technology has to have the capability to essentially send to a Direct address, which means it has to have Direct capability.

Wes Rishel – Independent Consultant

Right. The problem we have is that some people who read it – because of the sensitivity of this other issue, I think it says any Direct address, right.

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

It does.

Wes Rishel – Independent Consultant

All right. So some people have read that to say, we don't need no stinking trust relationships just as long as they follow the protocol, we don't care that it's the –

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

HIE –

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

Okay, so I want to capture that then, because it's an interpretation of the preamble of how –

Wes Rishel – Independent Consultant

Right.

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

Okay.

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

Okay.

Wes Rishel – Independent Consultant

Okay.

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

So we'll –

Wes Rishel – Independent Consultant

But then – what we didn't want to do is correspondingly say, you can't test this because we say you have to have a trust relationship, because the second half – the second sentence, I think was just to allow for a certification process absent the rather expensive process of being co-certified with the trusting body – the testing body.

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

Right.

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

Hey Wes, Kevin Brady. I think you're confusing the trust relationship with DirectTrust, what you're – I think what you want to say is you don't want them to be required to be part of DirectTrust to go through certification.

Wes Rishel – Independent Consultant

Personally, I would like to see everybody required to be in DirectTrust, but I don't think the government is going to do that.

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

Right, they're not. But we do test for a trust relationship at certification.

Wes Rishel – Independent Consultant

You form –

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

They have to install a trust –

Wes Rishel – Independent Consultant

You go through the mechanics –

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

Yeah, we give them –

Wes Rishel – Independent Consultant

– of doing what has to be done when a trust relationship is formed.

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

Right.

Wes Rishel – Independent Consultant

All right, that's the problem I have is that there's sort of the worldly and the technological interpretation of this forming a trust relationship.

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

Yeah, they just have to demonstrate that they can do it, but they –

Wes Rishel – Independent Consultant

Right, they have to demonstrate that they can go through the mechanics –

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

Right.

Wes Rishel – Independent Consultant

– according to the various specifications of accepting a trust bundle and then doing exchange –

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

– bundle –

Wes Rishel – Independent Consultant

– that's great, but they don't have to actually –

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

Do it.

Wes Rishel – Independent Consultant

– have a trust relationship with someone in order to do it, in the general sense of the word, which means, we've signed off on –

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

Well we do, I mean because –

Wes Rishel – Independent Consultant

– responsibility –

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

– trust anchor that we've signed off on, they give us a trust anchor that they've signed off on, so we do have a trust relationship with them, that's how they demonstrate that they can do it.

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

It's only for the testing though, correct.

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

Yes.

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

I mean that's the point. This is a – it's a testing methodology.

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

Right, it just shows that they can – if they can do it with us, they can do it with anyone.

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

Right.

Wes Rishel – Independent Consultant

I think we could spend another hour on the semantics here, but we can get to wording we need –

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

If we put down those three pieces and then what we'll do is – several of us will be there tomorrow and we can certainly clarify the question.

Wes Rishel – Independent Consultant

I'll be available on the phone tomorrow, so.

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

Okay. Well Wes, we will watch for your card to go up.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

The flavor of this conversation that says that we think that establishing trust relationships is crucial, but we're suggesting that that's – that there are mechanisms other than EHR certification to handle it, seems to me to be – maybe I've made things more difficult, I hope not. But it feels to me as though that's sort of the headline.

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

I don't know if I agree with that or not. I think that they have to test for it, that's – maybe when we read what Mike, because we're going to meet in the morning, Cris, maybe when we read what Mike – because you and I ought to at least agree, or maybe not, who cares. But let's read what Mike has gotten out of this and then we can make sure that we're – because I think its establishment of the trust relationship that's bothering me.

Wes Rishel – Independent Consultant

Yeah, there's nothing like a deadline to get to consensus and we still have 24 hours to go, so.

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

Absolutely. We're not making you nervous are we Michelle? Okay, let's go o – if it's okay Cris, I think we ought to go on.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup, yup, yup, let's keep going.

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

So the next one is around ambulatory setting and the discussion was we were really good with CDX for immunizations, but we had some issues around LOINC and the reasons are listed. And then there was one around situational dependency. The question was, or the comment was more how would we actually define an encounter for testing purposes, and I do believe that's more of a comment than a con – it's a concern, but it's saying, how do you actually make it legitimate for say an office visit, I'm going to finish the page and we'll come back to it.

On the transmission certification criteria, we couldn't find concern, so, we were – we felt like maybe we were in consensus or we didn't spend enough time, or I wasn't sure. I know Cris – the same.

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

This is Mike; the one – first bullet point does capture, I think, some of the concern.

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

The EDGE, yeah.

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

That – this is, you would have also – you have SOAP and REST and how would those – how would you ensure that they can communicate with the EHR without attesting an EDGE protocol for each of those, I believe that was part of the concern, but, I'll leave that open to the workgroup members to confirm.

Wes Rishel – Independent Consultant

This is Wes. We're looking at the slide that's got (e) (2) at the top?

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

It's got April 4 – it's got April 4 – yes, and it's – we're looking at §170.315(h).

Wes Rishel – Independent Consultant

(h), okay.

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

So the comment is captured that we're not sure how they would do the certification using transmit besides Direct, and the question was, would we need EDGE if we were going to do SOAP, REST, etcetera.

Wes Rishel – Independent Consultant

So – unclear how testing certification would ensure a C-CDA would be exchanged using transport standards besides Direct.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Our concern is lack of clarity.

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

Yeah.

Wes Rishel – Independent Consultant

Yeah.

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

So maybe that's what we – maybe that's – our comment –

Wes Rishel – Independent Consultant

Well, yeah, so maybe we could change that to a question that says –

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

How?

Wes Rishel – Independent Consultant

How would testing ensure that a C-CDA could be exchanged using transport protocols other than Direct question mark?

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

Yup, that works.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

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

Anybody else?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I like that formation.

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

And then on the family history, we talked about the HL7 pedigree and the implementation guide is new. Now here we have, it's in wide use, is that correct? It's new but –

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

No, it just says insufficient evidence that HL7 pedigree and the new – are in wide use.

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

Okay, so we're assuming it's not, we've got a double negative.

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

Right, I think – well that was the point made, I don't know, I think it was David McCallie or not, but the point being that –

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

Yeah.

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

– if we're going to propose that we should show that – ONC should show that it has – it's been established and – through that.

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

Okay, so it might be easier if we just said insufficient evidence that HL7 pedigree nor new implementation guide are in wide use, period. And then converging from SNOMED to the new pedigree was going to be complicated and burdensome. So we've gotten through the page, I'm not trying to rush us through the page, I want to go kind of back to §170.315 (e), we agreed on CDX, we put our concerns in around LOINC. Is there anything else there that we need to capture or talk to the committee about?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I don't think so.

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

And then family history, we talked about transition of certification. Family history okay? Okay. And then, like I said, Mike, if you'll take out "and the" and put in "nor," I think it will be easier to understand.

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

Yeah, I'll rework that; I'll just make it clearer that ONC has not offered sufficient evidence that that's –

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

Okay. And then here are – the next slide, which is April 4, continued on electronic notes. We have some comments here and they're rather lengthy, they're very good. I think probably just take a minute for people to read them and see if there's anything that you're not in agreement in terms of providing just kind of feedback to ONC.

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

Right, and there were – this is Mike again with ONC. There were four separate questions that we asked so that's why you probably – it seems lengthy, it's because they're responses to different questions. And we did get a couple of member feedback that has been incorporated here, two different members.

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

Now is it evident from the response what the question was?

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

Yes, I think these are responses to the questions, yes.

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

Right, but can you tell by reading the response what the question was, Mike?

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

No, I could try to work in the questions, I can make it two slides for you and put the questions in and line up the feedback with the question.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That would –

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

I mean, I'm just thinking that if it's not, then we're not – it'll be clearer – I don't know if there's any way of shortening –

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

Sure, I can do the same thing for safety-enhanced design, too. So I'll put back in – I'll put in the slides that ask those questions, and then you'll have, here's what the questions were and then we'll go to the next slide and it'll show, here's what your feedback was in response to those questions. And then I'll label – I'll try to label the feedback like, response to –

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

Questions 1 –

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

Yeah, exactly.

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

Are you all okay with doing that and then we'll take another look at it. I'm – my concern is again, we've got to sort out 10 more pages to go.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That would be helpful. Also, I think this is one that, these comments are not ones that came out of discussion from the group, correct?

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

Right.

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

Correct.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

We should just note those, Liz, as we're presenting these, that these would be ones we wouldn't want to color-code, except for to say, these were individual comments.

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

Correct, good point.

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

Unless – I mean, yeah, you may not have time now to reach agreement.

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

Right. That's – I think that's our concern is that it's not that we – without reading them, and we won't necessarily, so I think Cris is absolutely right, we should include the comments but recognize we didn't discuss them in the workgroup.

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

All right, I'll make those changes.

Wes Rishel – Independent Consultant

If I could propose one sentence that we might agree on –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Sure.

Wes Rishel – Independent Consultant

It is that the general availability of notes should be considered separately from the availability of structured descriptions of the notes and a lot of this stuff on this page boils down to, well, we can't really say what kind of note it is because we don't know what the standard is for that note and so forth. But the underlying concept here of the patient having a right to see their note is a pretty strong concept and if, in fact, only the text was available for some time –

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

Right.

Wes Rishel – Independent Consultant

– that would still be a – you could take the position that patient's access to notes is good or bad. I take the position it's good, but if we have that consensus among the people on the call there, I think we should make it clear that all of this fog of details is not meant to counter the –

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

This is Mike, just to give you a little background. So under – with the 2014 edition, what we did is, we said, notes, electronic notes have to be available now. And the question is how much capability does the EHR have to have related to searching those notes. And so we offered some questions related to that, should it be across all notes in the EHR? Should it be across just the patient's notes? Should it include metadata, which would make it easier to include it in like a C-CDA and send it? So those are what we're getting responses here to. There was no que – I mean, that does –

Wes Rishel – Independent Consultant

All right, all right. Okay.

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

– functionality to include a note is already there.

Wes Rishel – Independent Consultant

All right, I think seeing – if we see it with the questions directed by the answers, that'll be clearer, so – right.

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

Right, right.

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

Yeah.

Wes Rishel – Independent Consultant

Okay.

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

Okay, and then again, like I think Cris said, because the responses around the difficulty for the vendors to produce a – the security around patient access, I think the concern is that wouldn't necessarily represent the entire workgroup's, including mine and Wes and I'm sure others, disagree – or agree – we don't necessarily...it may be difficult, but it's sure a good idea.

Okay, let's go on to transmission. As you can see on slide 11, as you can see, we supported the implementation guide, that's why it's green, and we believe that it – there's – adds clarity to the whole thing. We, on the next one, we endorsed CDX again for immunization, vaccines, and we gave the reasons why NDC was not. And then on bi-directional we said it should not be a requirement, but we endorse an implementation for it, so, any comments on any of that feedback to the Standards group? Okay, we'll go to 12.

Better speak fast guys, ladies. Okay on 12 we're talking about transition to public health, syndromic and we did support the flexibility where we had alternative standards.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So on that one, Mike, I think I sent a note, I hope I've got it on my email box. I thought that that support allowing additional flexibility needed to be amended. I think the purpose was to allow credit for those who are submitting via CDA and QRDA III in addition to HL7 2.5.1.

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

Right, and maybe I can help explain that whole process.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Okay.

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

And just in one minute. So, what this new criterion, if you were already certified to HL7 2.5.1, you're certified.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Um hmm.

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

What it's going to offer any vendor going forward is, you can be certified to just one standard and your product is then certified. So you could come forward and out of the three standards, get certified just to QRDA and you would be certified to send – your provider would have certified product and could send QRDA and meet the measure. If you wanted to send using one of the other standards, you could not do that unless you were – unless your technology was certified to it for it to count for MU. So does that make more sense? So you can come to – you can get certified, not have to be certified to all three standards and still have a certified product, but if you want to use one of those standards –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

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

– your product has to be certified to it. Does that make sense?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

So the happy path is 2.5.1, but if you have an opportunity in your state, because of the presence of the public health HIE, which does good things, you would, as a pra – EP or EH need to go to your vendor and say, please get certified against one of the other two, so that I can count them against my attestation? Is that –

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

Right and if you have not been certified at all yet, and you wait until this Rule goes final and we go forward with this proposal, you would never even have to get certified to 2.5.1, if your providers that you are supporting only use QRDA III. You can come in and get certified just to QRDA III and you're good.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic.

I think that was the intent and it –

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

That makes sense to my –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I think I agree with it, yeah.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

I think that's an improvement over what, I want to say wasn't it the immunization standard in 2011, Stage 1, allowed for alternative standards, but I'm not sure it was ever clear that what you just said –

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

Right. No, I know, that was the 2.3.1 versus 2.5.1 issue.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yup.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

– better.

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

This is how we think it should be going forward, how to interpret it and how it would apply.

Wes Rishel – Independent Consultant

As a practical matter –

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

To make it clear for everybody, that's helpful.

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

Okay.

Wes Rishel – Independent Consultant

As a practical matter, doesn't it mean that all EHR vendors have to be certified to all three standards?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I don't think so.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

Well you could have a state that might accept multiple standards, I think it's going to be a –

Wes Rishel – Independent Consultant

No, you're going to sell your product in 50 states, the –

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

Yeah Wes, it could be more of an issue if you're – where you have providers that are public health is different in each state and then using different standards, yeah, it's a potential.

Wes Rishel – Independent Consultant

As a practical matter, if you're going to sell your product in all 50 states, you probably have to be certified in all three.

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

– all three. That's right.

Wes Rishel – Independent Consultant

Yeah. Okay.

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

And I'm sure that Cris and I can both attest to that.

Wes Rishel – Independent Consultant

Just want to emphasize that “or” is “and.”

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

It is – but I mean, because if it – I mean, there are folks that will be able to just get certified to one of them and if they're only doing – a small vendor. But there are a decent small vendors that get certified, so.

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

Okay, let's move on to inpatient updated implementation guide for surveillance. We did have a question. Did we check on the optionality or is that an ask of ONC to check on the optionality of 1.9?

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

I believe it was somebody – this is Mike with ONC – in the workgroup that said they would check with ISDS on that. I mean, I don't know if you necessarily need that for your comment, but I just want –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah –

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

But I just wanted to leave it as I had as an open note on that. So, I don't know if we have any feedback from the workgroup.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Was that John?

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

I was the one that brought that up, I'm sorry I did not think it to do to go follow up on the comment. I still can, so the basic question is, if we leave 1.9 in, we're really wanting to know if the jump from 1.9 to 2.0 is so big that –

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

– if we need to leave optionality, right.

John Travis, FHFMA, CPA – Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

– yeah. Let me follow up on that while we're speaking of it, I can do that.

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

Okay. And then use of QRDA I RFC?

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

RFC just stands for request for comment. I think we asked – we had that in there, ONC and I didn't – you didn't get to that issue, and it's okay if you don't, but we asked whether or not QRDA I would be appropriate option.

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

So, I would say at this point, so we can get through this, we should – Cris if this is okay, we should just not discuss.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I would drop it.

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

Okay.

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

Yeah, okay, drop it altogether. Okay –

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

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

Now we can – I think we'll go a little faster, I hope, so we can get to the general comments – famous last words.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Crack the whip, Liz, go!

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

I'm trying, okay. Slide 13, we agreed with the updated implementation guides on both of these. It was just simply getting it to where it needed to be, it made sense to us at the time. On 14, we talk about demographics; we had agreement on capturing the data, that's what we did. I thought there was one about the year, where is that Mike?

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

The year?

Wes Rishel – Independent Consultant

That was – you're talking about the – for patient ID?

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

Okay.

Wes Rishel – Independent Consultant

That was back under patient ID.

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

Okay, all right. We agreed with the standards on the – we recommended a standard for language. We agreed on the clinical decision support recommendations and the implementation guide. We agreed on the clarifications for the demographics. We agreed on the patient-specific education certification requirement using Infobutton and having an alternative that did not require Infobutton, and then again the implementation guide. So, any feedback on those pieces before we go to implantable device? Okay, 15.

So, we were very clear about – that we weren't ready for interoperability electronic exchange, that the template from HL7 does not fully align with FDA UDIs and that we need to pay attention to that. And on the safety-enhanced design we have the comment that were included – that were made there, but we did not think that there was a way to expand such enhanced design as part of the certification – again, it's an important concept, but it's not one that we think should be part of certification. Or that's what the group said. Any disagreement?

Okay, then I'm moving to non – I'm moving to slide 16, non-percentage-based measure report. And we did support the concept of capturing that for purposes of MU and that that would be part of the certification process, but to not be overly prescriptive. And it would be helpful if we could see some examples of how we might comply with that, so that when we're audited, we would know what to do, what to be ready for. Okay, here's what I'm going to do then. I'm going to tell you all that slide 17, slide 18, 19 and 20 were places where we received comments. We've included those now into this. We're going to be, much like Cris said before, we will be sure that it's clear that we did not discuss these as a committee, we simply reflected comments that were received. And so if you have a chance to take a look at those, again, several of us are on the Standards Committee and we can add that comment, certainly during public.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Actually, doesn't it go all the way through slide 21, Liz?

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

No, 21, what – so I'm going to be honest about taking a little license here. What I tried to do was create some overall comments, so the group could react to them. And I don't – if these are not overall beliefs, then we would again say, absolutely these are member comments only. If they're more general than that, I don't know Cris if we want to add anything about EDGE or either some other things we could do, you know asynchronous backward compatibility. We can go either way, we have just a couple of minutes, we can talk about those as a group or we can read these as other member comments.

Wes Rishel – Independent Consultant

I support these as group comments.

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

Hey Wes, was it asynchronous, bi-directional exchange.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

That's it.

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

That's it, okay. I just –

Wes Rishel – Independent Consultant

Asynchronous bi-directional upgrade I think, but –

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

Okay.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Upgrades.

Wes Rishel – Independent Consultant

Right. Yeah.

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

Yeah, we ought to add that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Liz, I would second that these be group comments. My only question would be whether the first comment – there might be comment on that from a rulemaking standpoint.

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

Well I asked that question directly out, because I just pulled these out of my notes and things that I've been worrying about. I asked specifically, Steve Posnack, would he – is it fair for us to assume that the 2015 edition would be included in the 2017 and he said you cannot assume that.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I get it, I'm just asking for a final confirmation before we –

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

Mike, yeah.

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

I mean, it's just – it's part of the – we can never do that, it's just part of the APA process, Administrative Procedure Act, we can never guarantee anything, because we always have to propose it and we have to get public comment and take that into consideration before we finalize anything. So, as much as we would like to say, this is a glide path and we can't guarantee – we'll never be able to guarantee anything, sorry.

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

Yeah, I understand. I just – the reason I wrote it is because I think it's important. I don't want there to be a presumption that if you go upgrade with 2015 that you are absolutely going to be able reuse that code for 2017 because I think that you will learn and there will be changes.

John Travis, FHFMA, CPA - Senior Director and Solution Strategist, Regulatory Compliance – Cerner Corporation

This is John, I understand that perspective that you can't guarantee, but there are definitely statements made in the preamble that indicate some of the arguments for the 2015 criteria edition are to give the market, vendors as well as implementers, lead time. One of the big arguments from a policy perspective for even doing it is to provide for a longer time horizon for gap development. So, maybe that's not a guarantee but it would be extraordinarily disappointing if that were the case.

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

Well –

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

Right, I mean I would like to think ONC would like to establish a sense of reliability in our policy, and so that's part of the process, that's all we can rely on.

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

So, I'm –

Wes Rishel – Independent Consultant

This is Wes.

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

Go ahead.

Wes Rishel – Independent Consultant

Two things, I think ONC would like to do a lot of things.

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

Right.

Wes Rishel – Independent Consultant

ONC needs to recognize that rolling out of standards is an evolutionary process.

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

Um hmm.

Wes Rishel – Independent Consultant

That there is no perfect committee that will define the perfect standard that will then go out and be implemented across the country without unsettled cases coming up about it.

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

Right.

Wes Rishel – Independent Consultant

Now that in itself doesn't mean that the investment made in meeting a 2015 standard wouldn't very likely be useful in meeting the 2017 version.

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

Right.

Wes Rishel – Independent Consultant

Best case it's not changed, middle case is it is changed, but the changes are minor compared to the total investment in doing the 2015 standard. My problem with the whole notion is not that of giving vendors a chance to look ahead, it's – what happens if my God, somebody implements these?

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

Yeah.

Wes Rishel – Independent Consultant

It's confusing enough determining which module certified in which year is eligible to allow it to support a Meaningful Use attestation as it is –

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

Right.

Wes Rishel – Independent Consultant

– considering the rollout of the modules is not instantaneous, it takes a year or more for the upgrades to the software to be rolled out. I mean, adding –

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

Right.

Wes Rishel – Independent Consultant

– just simply adding the idea of another edition in there with the forced march towards upgrades that providers have is objectionable. And sort of this possibility that a vendor says, well we only – this is an important bug you need fixed, but we're only going to support it in our 2015 version.

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

Right, and that's the kind of conversation I think we'll have in an open forum tomorrow. And like I said, I tried to listen to all the things that got said and just put these – I think this will be reflective of how many of us feel, I did not mean to in any way, put words in people's mouths. I mean, I obviously agree with them. Is there anyone who is uncomfortable with us bringing these comments up at the end as general, overall observations and then certainly encouraging the feedback from both the members of this workgroup as well as the committee?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Liz, I don't, I think these are great leadership, thank you.

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

You're welcome. And if there's nothing else, I know we need to go to public comment. Again, I know Cris and I can't thank people enough for their participation and the very short period of time, it's been tremendous and it's – that's how we get to this kind of a deck is with lots of people working on it. Very much appreciate it. And with that, let's open up Michelle for comments please.

Public Comment

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

Operator, can you please open the lines?

Rebecca Armendariz – 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 no comment at this time.

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

Great. Well thanks everybody, we'll be talking tomorrow and Mike, I'll be on a plane, I'm not sure where Cris will be, but I will have Internet access, so if I can help in any way, please let me know.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And Liz, last comment. I'm wondering, maybe we can talk about this tomorrow and just literally jump through the slides. But I actually think your closing comments would be good as preface. I'd like to make the case that we might start with that slide, if no one objects. I think it's a nice summary of the state of events.

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

To move that slide up.

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

Yes please.

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

Do I need to; I guess this is a matter of procedure now. Do you want to see the – I'm going to try to revise everything based on what I heard and then send it back to you two before we send it to – out?

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

Well, like I just said, I'm in the air for the next three hours, I can see it immediately, I don't have – Cris is usually – I mean, it's only because I'm in the air do I have time.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

I can take a look at it on behalf of both of us Liz, if that's okay with you.

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

Absolutely.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

But I'm sure the changes, Mike, will be great.

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

Yeah, and that's –

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

I think the only one that is really going to need a close eye is going to be the VDT one.

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

So why don't you, if you'll get that right back to us, we will – we understand it needs to get out immediately.

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

Okay.

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

So we'll respond immediately.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

And I would say actually, if you want to distribute it to others, I'm happy to have others –

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

Absolutely.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

– and anyone who wants to comment on it would be fine, I'm guessing we'll get to good consensus.

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

Yup, sounds great. Thanks everybody. Bye.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks all.