

Clinical Operations Workgroup
Draft Transcript
March 26, 2012

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Good morning, this is Mary Jo Deering in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Standards Committee Clinical Operations Workgroup. It is a public meeting and there will be an opportunity for public comment at the end. I'm going to begin by taking the roll and then asking staff to introduce themselves. As we are having a transcript made of this I would also ask all parties to identify themselves when they speak. So, going onto the roll, Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Present.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

John Halamka? I know he's coming late. Don Bechtel?

Donald Bechtel – Health Information Technology Standards Committee

I'm here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Chris Chute?

Christopher Chute – Mayo Foundation for Medical Education and Research

Present.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Martin Harris? Kevin Hutchinson? Liz Johnson?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

John Klimek? Nancy Orvis? Wes Rishel? Cris Ross? Joyce Sensmeier?

Joyce Sensmeier – Health Information Technology Standards Committee

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Karen Trudel? Stan Huff?

Stanley M. Huff - Intermountain Healthcare

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Ex-officio Jay...? Terrie Reed? Terrie, are you on mute? I think she is here. Okay and would the staff please identify themselves?

Anand Basu – Office of the National Coordinator – Standards Division

Anand Basu from ONC.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Mike Lipinski, ONC.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, thank you back to you Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great, thank you very much. So, thanks, everyone for joining this call. This is the first of three, series of three calls to develop comments from the Workgroup to propose as Standards Committee comments back to ONC on the NPRM for standards and certification for the 2014 edition supporting Meaningful Use Stage 2. What I'd like to do and would like to get comments on first, even before we cover the agenda for this meeting is to outline a plan for conducting the series of three meetings and see if this is acceptable to everyone.

What I want to propose is that we increase the structure and specificity of the calls and comments as we go through the calls. So, today would be the least structured conversation where we would really elicit from all the Workgroup members thoughts and feelings about areas on the rule that we feel are in the purview of Clinical Operations Workgroup including vocabulary items upon which we feel that the committee should comment. And so this would be more of an open discussion today, possibly leading to drafting some specific comment text today that then I can go off and start to draft some initial comment areas as a result of this call, but most of the drafting actually would occur as a result of the second call.

So, the second call we would get into the content of specific comments, start to draft and review draft comments, which then off-line I can refine through e-mail with others, refine proposed comments which we would then review and finalize on the third and final call. So, that's a proposal for how to conduct the series of three calls. And how does everybody feel about that?

M

That seems like a very reasonable approach.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, any other comments?

M

I concur.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes, it works for me.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great, and just a note our Co-Chair John Halamka will be joining us late, he should be here in about half an hour. He had a present engagement.

Stanley M. Huff - Intermountain Healthcare

Jamie, I need to leave early, I'm going to have to leave about, yeah, I'm going to have leave after an hour.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great, thank you, Stan. So, I guess we'll just open up, my thinking is we would start with an open discussion identifying priority areas upon which we want to comment and then assuming that we will run out of steam on that approach some time during the call and we can start to just look through the template for input that has been very kindly provided by ONC and see if we can identify additional areas

that we may want to comment on. So, who has a hot topic that they are sure we want to comment on to start the discussion? Wow. Well, okay, so I think let's talk perhaps about some of the vocabulary issues as a starting point.

One of the items that came up in our last Standards Committee meeting was the issue of SNOMED CT being proposed for problem list, but ICD-10 being proposed for encounter diagnosis and a question came up as to the applicability of our previous recommendations for the use of SNOMED CT where just to recap that, we had been asked as a Workgroup to identify standards that would be used for quality reporting and so we identified the use of SNOMED CT for problem list for quality reporting, but in fact we weren't asked to identify something for encounter diagnosis documentation and so the question is if we were asked that now, would we expand the use of SNOMED to the diagnosis or just keep it in the problem list?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Jamie, this is Mary Jo, I apologize for interrupting you, but I just noticed that you had mentioned three meetings. Currently you only have two meetings scheduled, you have today and then you have April 11th. So, I wanted you to have that in mind. We can certainly work with you to schedule a third.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, I'm sorry I had thought we were going to schedule three meetings.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I think it didn't work out. I think we couldn't find time for you and John.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Oh, okay.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I just brought it to your attention, so we can work on it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think if it's okay with everybody, the basic plan to increase the specificity and review of comments can continue with on-line review and finalization of the comments in place of a third call, if that's acceptable to everybody.

M

Yeah, that should be fine.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

M

Yeah to address your question, I guess it has to do with probably understanding more about the use case for the encounter information. I mean, if the real meaning of that field is what was the billing code for this encounter, then I can see, you know, it being appropriate to have that be an ICD code. If that is intended to be, if you will, the clinical diagnosis for this visit, then it would seem appropriate to unify that to be SNOMED.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So, actually, I think maybe, Mike, if you're on the call, what do you see as the intent of that? I think we lost Mike.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

If he is not on mute.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Hi, this is Mike.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Hi.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Sorry about that. So, can you repeat that question real quick?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Sure, the question is really, what's the intent of the encounter diagnosis information standard that's proposed in the rule? Is it really for the clinical diagnosis or is it really intended to be the billing code? Because the question came up in our last Standards Committee meeting on whether it would be appropriate to expand the use of SNOMED CT into that area or not as a committee recommendation, bearing in mind that previously we had recommended SNOMED only for problem list only because basically we were asked to make recommendations for problem list for quality reporting purposes and not for other purposes.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

All right, so I caveat everything right now with the fact that we're in an open comment period, so in terms of our rationale it should be limited to what we said in the rule. I'm not in a position to offer additional rationale at this time, but I can say as clear in the preamble about the problem list that we went to SNOMED because we wanted to be more clinically focused and we also said the same thing in use of ICD-10 for, I believe it was capturing mortality, so if that helps at all. I don't think we get into a discussion anywhere else regarding ICD-10 as to whether the intent was billing or clinical, but I can say I think throughout the preamble where we do discuss, you know, use of these standards we are focused on the clinical aspect.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Does that help?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, it sounds as if the intent...obviously reading between the lines, but it sounds as if the intent is more clinically oriented rather than towards the financial use case.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

I think that's fair to say.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And, so Stan what do you think in reaction to that?

Stanley M. Huff - Intermountain Healthcare

Well, I think we could say it, sort of, we could leave the doubt in there, I guess, say, you know, if the intent was that this reflects the billing code, then ICD is appropriate. If not, you know, if the intent was to capture clinical detail then we would recommend that you go to SNOMED. And I mean, you could argue, I guess too that if actually they were interested in both that you should have two fields, one that was called something like clinical diagnosis and the other one was called, you know, billing diagnosis or classification.

Joyce Sensmeier – Health Information Technology Standards Committee

This is Joyce Sensmeier; I definitely agree with that. I think some of the critique that I've heard about this topic is focused on that there are recommendations for both SNOMED CT and ICD -10. And I think what I hear articulated is that if there is a good reason to identify one or the other, we need to be clear about that so that we could say, you know, for consistency for the clinical aspect, we're looking to SNOMED-CT but there are instances for these particular reasons where ICD-10 is recommended. Those are some of my thoughts.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

It sounds like you've got a consensus. I certainly agree with that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

Christopher Chute – Mayo Foundation for Medical Education and Research

Yeah, this is Chris. I don't disagree with it, but I do want to raise, how do we phrase this, the clinical friendliness of SNOMED and indeed the whole question of pre-coordination versus post-coordination. I mean the reality is if you want to use SNOMED intelligently to capture clinical detail you get yourselves into a post coordination kind of thing and either that or you inevitably make up clinically friendly terms that are mapped to some kind of SNOMED expression or term. And I think we all recognize that SNOMED out-of-the-box is not terrifically clinically friendly. And so I guess part of this is a bit of a non-sequitur to your question, Jamie, I'm going off on a bit of a tangent and you can rein me back in, but how should we recommend that that reality be addressed?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, I guess in response, I have two comments. One from our experience in my organization here and another one from I think an EHR certification perspective. From our perspective as a big user of SNOMED in the clinical environment we do have interface terms which are alternative descriptions that are found to be clinician friendlier terms for some of the SNOMED items. We use well over 100,000 SNOMED concepts on a regular routine basis, but what I'll say is that the vast majority of those actually, the SNOMED description for the concept is actually preferred by our clinicians. So, the notion that it's not clinically friendly certainly applies in some cases, but I would say that that's actually a small minority of the cases, albeit in sometimes very frequently used terms.

And then I guess the second thing is that it's certainly possible and there are a number of commercial as well as private and publicly available interface terms, including those that we've donated through the NLM into the public space as well as private and commercial alternatives to deal with the issue of the clinician-facing interface terminology. So it doesn't actually relate to the previous standards question, but I think it is a question about the applicability of SNOMED overall and so maybe it's something, maybe that's a separate comment that we should make about the selection of SNOMED either supporting it or identifying the need for further guidance.

Christopher Chute – Mayo Foundation for Medical Education and Research

Yeah, that's exactly the direction I was suggesting. So, yes I would certainly support that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, well how do others feel about this issue? I mean, you know, my own viewpoint is as I said, that these are things that can be dealt with, but is this a widely perceived problem that we should take into consideration and any other recommendations?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, Jamie, our experience here at Tenet is very similar to what you've described at Kaiser. Our clinicians do not find it a problem. They prefer SNOMED.

Stanley M. Huff - Intermountain Healthcare

This is Stan. At Intermountain I think the SNOMED wording usually works fine. In general we present a much more pre-coordinated terms to our clinicians, which, you know, I think can be represented quite accurately by a combination of SNOMED codes in an expression, but in our user interface the clinicians don't like clicking on a bunch of different boxes, and so, you know, we pre-coordinate much more than what the current style is in SNOMED. But I guess depending on how what's intended we can, you know, we can decompose, or you know, those more pre-coordinated expressions into a combination of individual SNOMED codes that represent the same meaning most of the time.

Donald Bechtel – Health Information Technology Standards Committee

So, this is Don; I just wanted to concur with what I heard Joyce bring forward, that we should be very clear on what our intents are, whether we're planning to use ICD-10 or when we're planning to use SNOMED, but I can't comment on some of these other issues you're raising.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

But, I think Stan brought up an important issue for the actual implementation of SNOMED in the problem list, which does have to do with the presentation to clinicians, and I have to say I am not familiar with the proposed certification specifics of how the clinician usability issues would be addressed where it's desired to use a post coordinated term as both Chris and Stan have mentioned. So, Stan said that their approach is to present it as a combination in a pre-coordinated manner. I don't know how that's presented to clinicians or if indeed that question is even addressed in the certification process.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, I don't either.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, maybe Anand or Mike if you could comment on the degree to which the usability of SNOMED in terms of clinician documentation is intended to be addressed by the certification process, maybe that could help our comments.

Anand Basu – Office of the National Coordinator – Standards Division

Mike do you want to?

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Yeah, there is not much I can say to this, because we haven't developed, to my knowledge yet, a test, you know, a draft test procedure for this, the use, you know, related to SNOMED. I want to say SNOMED is somewhere else right now, but I can't recall.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, it has been in the summary record.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Yeah, that's where...I knew it was there. So, I'm not familiar with that test procedure, so I'd have to defer on that one.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And that doesn't really deal with the actual clinician documentation of the problem list, just in its representation for external exchange.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Right, so as far as problem list goes, you know, we haven't even, to my knowledge we don't even have draft test procedures yet.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, so maybe this is something that we could develop a comment on in terms of requirements for usability.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, what other items are there? So, I think we've for now, for this purpose likely exhausted that item. What other areas are there that folks may want to comment on? That folks feel we should develop Workgroup comments on?

Stanley M. Huff - Intermountain Healthcare

You know, I think, I have to confess to some lack of preparation. I probably need to review more details to answer that question, Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

M

Well, if Stan is going to confess I'll join the line.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, I mean, you know, there has been certainly a lot going on and this is, you know, a huge rule with a lot in it, so I think it's understandable if not everybody has read all of it in detail and is completely familiar with it, but I will have to say...and I guess Mike this is thanks to you and to Steve, it is much more readable than the previous versions.

Mike Lipinski – Office of the National Coordinator for Health Information Technology

Well, I appreciate that. I'm not going to say anything negative about Steve. This is the first time I've worked on this standards rule. I worked on the certification rules the first time around. But I also know we were under a pretty tight timeline this time around.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah, yeah. Okay. Let's see, one other area that came up, so there were a couple of other areas that came up in our previous Standards Committee meeting I'll bring to light here, one of which had to do with the discharge ePrescribing and I guess the fact that that specifies that NCPDP script should be used. I think there may be a minor issue on the version of script, as I understand, but I think the primary question is whether there are any nuances to the application of script for discharge ePrescribing, and I guess my understanding is that a number of the inpatient pharmacies, so when an inpatient pharmacy is used to fill a discharge prescription sometimes the pharmacy that's within the hospital is in a separate legal organization.

And so my understanding is that the way the systems currently work is that in most hospitals is that whether the pharmacy is in the same legal entity or separate legal entity HL7 is used within the hospital, but that this proposal, the proposed rule would now require using NCPDP script as if it were an external pharmacy for filling the discharge prescriptions. So, I guess in the first place, what's the experience of, we have a few hospital systems represented on the call. Do you have discharge prescriptions that are filled by the hospital pharmacy? And I guess then do you use HL7 first or NCPDP or how do you do that?

John Halamka, MD, MS – Harvard Medical School

Hi, Jamie, it's John Halamka just joining.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Hi, John.

John Halamka, MD, MS – Harvard Medical School

I apologize for the delay; the CEO had a command performance that I couldn't miss.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great, thank you. So, John what we're doing is and I apologize, I thought we had three calls, it turns out we have two calls of the Workgroup for this and what I've suggested is that today should be a relatively unstructured call just to get ideas about areas that we may want to comment on and in fact, we've already outlined a couple of possible comments. But then really on the next call we would do most of the drafting and then review by e-mail the final comments. So, this was intended to be more of a free-form call to get out ideas of different areas that we want to develop comments on.

John Halamka, MD, MS – Harvard Medical School

And that makes great sense. I mean as you look through for all of the content and vocabulary portions of the NPRM, you know, what are those confusing points and got yous, I've certainly heard on the transport side that there's a lot of ambiguity in the language that people don't even actually understand what it says about the use of Direct and XDR and XDM, it is shall, is it should, is it must, is it might, what is optional?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

John Halamka, MD, MS – Harvard Medical School

So, those sorts of issues raised today make great sense.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah. So, what we've talked about thus far is the intent of encounter diagnosis where, you know, SNOMED is proposed for the problem list, but ICD-10 for the diagnosis and we have both Mike and Anand from ONC on the call, and what we heard was that the general intent of ICD-10 as expressed in the rule is really to capture clinical information and not the billing or financial use case. And so what we've come up with is a recommendation to say that if the intent is clinical then in fact SNOMED should be used for the diagnosis, but that if the intent is for the billing use case, then ICD should be used and so that should be made clear. And then if the intent is both then it may be desirable to add a second field and specify the clinical diagnosis versus the billing classification.

John Halamka, MD, MS – Harvard Medical School

Makes great sense.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We also talked about developing a comment about the need to support usability in the certification process for the clinician friendliness of SNOMED implementation. So, if SNOMED is actually going to be required to be used for documenting problem list then there should be some usability to ensure that where there may be a need for post coordinated expressions to be documented in the problem list, that that can be dealt with through some usability test.

John Halamka, MD, MS – Harvard Medical School

Perfect. Now have you talked about the vocabulary issues around allergy yet?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

No, no we haven't gotten there yet.

John Halamka, MD, MS – Harvard Medical School

Okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I had just opened up a discussion on discharge ePrescribing and so maybe we can finish that and then get back to some of the other vocabulary topics.

John Halamka, MD, MS – Harvard Medical School

Perfect.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

All right, so in terms of discharge ePrescribing my understanding is that a number of the inpatient pharmacies in hospitals that currently use HL7 are actually a separate legal entity within the hospital structure and so the way the rule is written it would actually require those, for this purpose, to shift to using the NCPDP script. So I guess Chris, Stan and Liz, you all have hospitals, and John, how do you do it internally and would that be a problem for you?

John Halamka, MD, MS – Harvard Medical School

So, when I talked to Farzad about this one, this is again one of those intent issues, the intent was they wished to encourage interoperability between disparate organizations to all use the same standard stack. So, you wouldn't want an HL7 flow to a retail pharmacy 10 miles away in a sense, that was the intent, obviously their intent and our intent was slightly different, because to your point, we have a pharmacy that dispenses that is not a legal entity associated with the hospital, it just happens to share the same proximate space and we use HL7 rather than NCPDP for those transactions.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

John Halamka, MD, MS – Harvard Medical School

And so I think it's a question again of the intent of absolutely we would never use HL7 to go over a Surescript select connection to a CVS or a Walgreens, we just are sort of stuck with this relationship of a proximate partner inside our facility with a flow of data from an existing hospital information system.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah, and actually within an organized healthcare arrangement under HIPAA, so there is an organizational tie, but it's a different legal entity.

John Halamka, MD, MS – Harvard Medical School

Right.

Christopher Chute – Mayo Foundation for Medical Education and Research

Yeah, this is Chris; we have a shared legal entity and like I guess most of the others an HL7 feed to our local dispensing activities. I imagine the same is also true on the outpatient basis.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

And excuse me I have to ditto we're using HL7 and we certainly looked at this now when we saw the recommendation come out was when we are anticipating it anyway just like we looked at it in the Implementation Workgroup in the recommendation of NCPDP 10.6. So, that is where we are, but we're HL7 today, but we're not going to outside facilities.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, is this an area where we would want to recommend recognition of an HL7 prescribing message? This is I think what we did in the previous Standards Committee recommendations was we recommended that essentially any HL7 would be easily testable in the certification process, we got that feedback also from NIST that the testing for a compliant HL7 prescribing message would be a relatively easy test. We want to go back and essentially re-iterate that recommendation, which then would recommend a change to the I guess 2014 addition rule to provide recognition of HL7 where it happens within the same hospital.

John Halamka, MD, MS – Harvard Medical School

Well, here's the interesting question, Jamie, is that when I talked to Farzad about this, what he said was "we don't intent to regulate the transactions that occur inside an organization."

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

John Halamka, MD, MS – Harvard Medical School

So, in effect by being mute on the topic you can use whatever you want and so that's sort of an interesting question, which is if you have this interesting situation where their intent is to encourage interoperability across disparate organizations with some geographic distribution and they regulate that and certify to that, do they even need to certify to the fact that your hospital information systems communicate with a pharmacy inside your four walls.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I guess it comes down to perhaps the relationship of the standards to the measures.

John Halamka, MD, MS – Harvard Medical School

Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Because if to count for the measure of discharge prescriptions that are electronic, if that requires the use of the standards then that's a different kettle of fish.

John Halamka, MD, MS – Harvard Medical School

That's true.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, I think this is one of those cases where, and perhaps that could be part of our comment.

John Halamka, MD, MS – Harvard Medical School

Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That so long as the use of the standard is actually not required for either the numerator and denominator in the measure, then the way it is, is fine, but if there is a tie to the actual use of the standards then this would be, you know, a big change for most hospitals.

John Halamka, MD, MS – Harvard Medical School

I agree and so I think as you've said, we say "gee, if your intent was interoperability across multiple disparate organizations" and our intent here is to basically classify this as inside an organization and we'll still do the measure, but it doesn't require the use of a particular standard, its internal operations and we'll count numerators and denominators but there's no standard involved, if you want a standard, if you want to enforce a standard, then you better offer the HL7 formal option.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Exactly. Okay, so I've got that in my notes. John, you had mentioned, just switching gears now if we're done with that one, first, let me just test. Is there anything else on that topic? John, you had come on mentioning the issue of the allergy vocabulary. Do you want to go into that a little bit?

John Halamka, MD, MS – Harvard Medical School

Absolutely. So I think Farzad admits that this was actually an oversight that it wasn't that the folks at ONC purposefully left out any allergy vocabulary, it's that they failed to recognize that there had been a body of work done by both HITPC and HITSC on this and that we probably should make some statement on the use of RxNorm for substances, NDFRT or now that it's included in RxNorm, RxNorm itself for a category and then some vocabulary whether that's SNOMED, UNI, etcetera for the non-medication

substances for which there is an allergy. So, I think they are looking for our comment and would find it highly desirable to include some statement on medication and non-medication allergies and categories.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah, and I think as you just eluded to, because, you know, these things are now, they are all in RxNorm, I think it really comes down to the identifier that is going to be used and, you know, so is it the, I guess the Rx CUI that should be used to identify the ingredients for medications or not.

John Halamka, MD, MS – Harvard Medical School

And the answer of course, if a parsimonious solution like, oh RxNorm is now ready for primetime and has enough of the crosswalk in it that would enable you, if you want to use, something else inside your internal systems, that it can be cross walked to an Rx CUI that's probably fine. I would defer to others with wisdom on this topic.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, how do folks feel about this one?

Stanley M. Huff - Intermountain Healthcare

Yeah, this is Stan, I would certainly be in favor of making a recommendation and I'm trying to keep up and make sure, you know, typically allergies are broken into, you know, medications, environmental, and food. At least those are the classifications we used and for medications, yeah, I think it would be, you know, RxNorm and we should say, I mean what the person knows is that they took this pill and the reaction that happened, and so, you know, you can note things at, if you will, the pill level especially when there is a combination of ingredients in the pill and then pure ingredients if by whatever reason you assume that's what's going on.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right and I think that's the question is primarily about the ingredient level including the inactive substances, which I believe now have been added to RxNorm.

Stanley M. Huff - Intermountain Healthcare

Yeah.

Terrie Reed – Food and Drug Administration

This is Terrie Reed at FDA. I'm in the device area so I'm obviously not an expert on medications, but I wondered if someone at FDA CDRH had been engaged in these conversations, because I know they deal with UNI and allergy lists. Should I go back and get information from that group or have they already been engaged?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I don't think that group has been engaged. We have had, although she's not on this call, we have had Betsy Humphreys from the National Library of Medicine engaged in this conversation who I think has assured us that in fact...so UNI is now in RxNorm.

Terrie Reed – Food and Drug Administration

Okay. All right, I'll just take that back.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, I think the question is really about which identifier we should use rather than...so we had previously made a recommendation that UNI should be used for the unique ingredient identifier, but now that UNI is in RxNorm, I guess really the question is should we switch our recommendation to use the RxNorm concept ID for the UNI concepts?

John Halamka, MD, MS – Harvard Medical School

And what we do in our internal systems, where at a first databank shop and we purchased from first databank the FDB to RxNorm mapping. So although we have FDB proprietary codes internal to the system

RxNorm appears on all of our interoperable data flows. So I don't think in our case we care as long as we can map from what we're using today to some standard CUI and RxNorm is what we have just mapped to recently, we're good.

Christopher Chute – Mayo Foundation for Medical Education and Research

Yeah, this is Chris; I stepped away, but when we're talking about RxNorm for allergies, we're in allergies aren't we?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

Christopher Chute – Mayo Foundation for Medical Education and Research

We have to be careful to make sure that we use the RxNorm generic code as opposed to pill sized specific code and those are very different things within RxNorm. We don't want to get into a situation that you're allergic to a 200 milligram tablet if you're prescribed a 400 milligram tablet it wouldn't fire.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So, that's a great point. I think Chris while you had stepped away the other part of the discussion was really about the ingredient level information now that UNI is in RxNorm. We had previously recommended using UNI, which meant the UNI identifiers, but now it would be the Rx CUIs for the UNI concepts at the ingredient level including the inactive ingredients.

Christopher Chute – Mayo Foundation for Medical Education and Research

Ah, so I should have just kept quiet and listened? Thank you.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Oh, no, no, no that's okay, but would you agree with basically switching our recommendation to be essentially using the RxNorm CUI to the Rx CUIs for everything that is in RxNorm, which would be actually a change for vendors who are complying with UNI today?

Christopher Chute – Mayo Foundation for Medical Education and Research

I think for purposes of consistency, that would be desirable, minimizing the number of reference data sets particularly if UNI's Incorporated, and I believe you're correct it is, then it's really a function of which identifier are going to use and having parsimony in our identifier universe, so to speak, is a desirable thing. So, yes is the answer, I would support that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Great. Thanks very much. Great discussion. Is there anything else on the allergy vocabulary that we want to talk about on this call? Okay, another item that John mentioned was the transmission protocol standards and I have to admit I have not fully parsed out the language in that to a complete level of understanding myself.

John Halamka, MD, MS – Harvard Medical School

Dixie Baker's group on Privacy and Security is going to handle a set of recommendations there.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

John Halamka, MD, MS – Harvard Medical School

But basically, on my blog last Friday I actually spent a good amount of time on the phone with Doug and with Steve Posnack to try to actually describe the intent of what they wrote.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay.

John Halamka, MD, MS – Harvard Medical School

Because, the question is something like this, when you say Direct what do you mean? Do you mean S/MIME, SMTP? Do you mean SOAP? If you mean SOAP is it specifically XDR? And then what's funny about the Reg is it's written actually in 2 places, one says you must use Direct, the other says you can use SOAP as well. So huh?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

John Halamka, MD, MS – Harvard Medical School

And the way it's phrased in the transitions of care section is its SOAP without an implementation guide other than the SOAP, you know, general implementation, you know, 1.0 RTM, it's not XDR or XDM, etcetera.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

John Halamka, MD, MS – Harvard Medical School

And so, their intent is basically this, that you should as a vendor support both S/MIME, SMTP and XDR. That's what I gather from the conversations with them. Doug, I mean Arien had proposed, well why don't you say everyone must do SMTP, S/MIME and optionally can do XDR on top of it if they wish as an on ramp and off ramp? That is not what was written into the Reg. It's really that the vendors have to do both.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, my own feeling is that it certainly would be a better aid to interoperability if both were equally required. In other words, just require both of the vendors, make it explicit and then leave the choice up to the implementer as to which to use.

John Halamka, MD, MS – Harvard Medical School

So, what we're seeing in Massachusetts is that although we have piloted Direct and we're creating a Direct backbone, the SMTP, S/MIME is really used for HISP to HISP communications and actually all the EHR vendors are doing SOAP to get to the HISP. So, you're right, I mean having both gives you ultimate flexibility, but it will be very interesting to see how the market goes on this one. I have a feeling we're going to see SOAP adopted much more than the S/MIME SMTP protocol for the average EHR vendor.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right, and SOAP certainly is what we're using although we're using the more expanded specifications of the NwHIN as are I think a number of the other organizations on the call.

John Halamka, MD, MS – Harvard Medical School

Yes. So, as long as we, I mean and again we'll see what Dixie's group comes back with, but I think something to the effect of you should have a SOAP-based interface and an S/MIME SMTP interface in your product, would probably meet...

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, but I think in terms of scope, I think it's reasonable for us to perhaps collaborate on that.

John Halamka, MD, MS – Harvard Medical School

Sure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Because from a security perspective, you know, that is certainly one perspective, but also there are obviously clinical operations and workflow implications, because the workflow presentation of e-mail SMTP is usually somewhat different from the usability and user implementation of the query response mechanism using SOAP.

M

Well, that's actually the heart of it. I mean, our organization is quite adamant that we have the ability to do a pull in addition to a push. SMTP is essentially a push and we're quite happy to implement that, but as you know, Jamie and the continuity of care consortium and for that matter in Southeastern Minnesota Beacon, the ability to do an enterprise-wide pull, assuming authorizations and certificates are all in place, is going to be crucial and we can't do that with the Direct protocol as it is structured.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So, well that would support actually I think a recommendation out of this Workgroup that both should be required equally.

John Halamka, MD, MS – Harvard Medical School

Right and recognize that of course there are cheating ways to use Direct to do a pull and that is, I e-mail you a request to send to me the data and then the data is sent. So it's a push-push equals a pull.

M

But that effectively requires human intervention unless you're going to have, you know, another software layer monitoring e-mail and queries to do this kind of...it's a kluge.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Which goes back to the workflow issue.

John Halamka, MD, MS – Harvard Medical School

Well, no absolutely. No, I was just pointing out that I hear some people saying exactly what you say, which is basically Direct gives us push but we need pull and what do we do in the interim? Oh, well you could do an XDR message that's a push that is in effect, you know, a command to send me, to a specific address, a response and so it's XDR to XDR or SMTP to SMTP, but two pushes equaling a pull, not ideal. And, so I think the issue, from the perspective of ONC is are we at a point now where we can recommend the NwHIN specifications as written or is there additional refinement needed to those NwHIN recommendations? And, I think Dixie's team is working on such things as how does the provider directory really work in the context of the NwHIN specifications.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

But, that's outside question of the transmission protocol. I'm sorry.

John Halamka, MD, MS – Harvard Medical School

Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

You know, if we're just talking about the transmission protocol, those are really peripheral questions.

John Halamka, MD, MS – Harvard Medical School

Right and it's just the whole implementation guidance, but saying, SOAP and SMTP, S/MIME are both required probably covers it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I would support that as a Workgroup comment, that both should be equally required. How do others feel?

Joyce Sensmeier – Health Information Technology Standards Committee

This is Joyce. I agree completely.

Donald Bechtel – Health Information Technology Standards Committee

This is Don, as a vendor, I would agree.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Because you're going to have to do both anyway, right?

Donald Bechtel – Health Information Technology Standards Committee

Yeah, pretty much.

Stanley M. Huff - Intermountain Healthcare

Yeah, I'm fine with that too. This is Stan.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, so what we're talking about is a recommendation that both SMTP and SOAP should be equally required, is that right?

John Halamka, MD, MS – Harvard Medical School

Works for me.

Joyce Sensmeier – Health Information Technology Standards Committee

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, good.

Joyce Sensmeier – Health Information Technology Standards Committee

Jamie, this is Joyce, this is much smaller in scope in comparison to the previous discussions, but I would like to have us ask for a correction in this transport discussion here, it's specifically around this objective view, download an transport to third-party. They reference XDR and XDM for Direct messaging as a subset of the Direct specification, but there's also text that refers to XDR and XDM separately, and I would request that we use their actual name, which is IHE XDR and IHE XDM.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, yes.

Joyce Sensmeier – Health Information Technology Standards Committee

Thank you.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Good. Okay. Let me bring up a different issue that I've heard a couple of times, but has not been brought up in this forum, well first of all, sorry let me check, are we done with the transmission protocol discussion for now?

The other item is that when we talked about the requirements to capture or share information about patient lists, there isn't a named standard for lists of patients and yet both for capturing information in for example disease registries or for other care coordination on a panel level, the ability to transmit list of patients using a standard would be desirable. And certainly this is an area where it is possible to use HL7 CDA in this way. There is not a specific implementation guide for that, that I'm aware of, there may be one but I'm just not aware of it. And so I just wanted to open up the discussion on this item about lists or panels or groups of patients and how to potentially capture and transmit information about more than one patient.

John Halamka, MD, MS – Harvard Medical School

That's a really interesting question and so for example, let me give you two scenarios. One scenario would be, I want to send a series of lab results for registry, do I have multiple HL7 2.X messages in a single envelope? Do I use some kind of CDA type format to represent that?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Or a weekly upload to an immunization registry?

John Halamka, MD, MS – Harvard Medical School

Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

You know, but that may be a different case where there is already something, but...

M

That's 2.51 for immunization...

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

John Halamka, MD, MS – Harvard Medical School

But what we found for example when we went to do this with NHIN it's a really good case, Jamie, that we did...our current NHIN gateway expects one HL7 2.5.1 message per envelope.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

John Halamka, MD, MS – Harvard Medical School

So having 50 in a single envelope at the moment isn't supported, so you're right it's a need, it's not clear if it was envisioned by a lot of the existent infrastructure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well and I guess my view is that this would be sort of the clinical analogy to batches of claims as opposed to individual claims transactions. So, how do batches of patient level data work?

John Halamka, MD, MS – Harvard Medical School

I'm not aware specifically of CDA format, although as you say, you know, there may be someone that does that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, I have done a little bit of investigation and some of the HL7 Workgroup Chairs are providing information about specifications for doing exactly that, which I think can be done in Version 2 or Version 3 or CDA, but I guess, let me just ask the group, is this an area where we should recommend that a standard should be defined?

John Halamka, MD, MS – Harvard Medical School

I mean, certainly, we've already run into this use case as needing definition and that's for historical batch uploads of immunization data or for interval submissions rather than real time. So, certainly it would be good to get some commentary from the SDO's on it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And so again, I think the primary use case is for registry updates. Are there other use cases that should be explored for this idea of groups or lists of patients?

John Halamka, MD, MS – Harvard Medical School

Just one quick comment, it's tangential, but in doing the popHealth analysis in...with MITRE it was clear that the CCD C32 isn't actually a good mechanism of submitting complex data to registries necessarily, because it has some optionality, it has some looseness that makes it less than perfect. So, I think what you're getting at is there is this sort of broad question, which is, how do I submit multiple patient's data in batch to a registry, and even if I wanted to submit data from EHR to a quality repository, which standard would I use even for a single encounter? Where CCD, you know, its okay, it just was never was intended for that purpose and needs some refinement.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

John Halamka, MD, MS – Harvard Medical School

And you'll find this kind of interesting. The MITRE people found something quite shocking. They thought the CCD would be a longitudinal lifetime history summary record. In fact, it is an encounter summary record. And so saying things like in the last 10 years have you had a mammogram is something you can't discern from an individual CCD.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

John Halamka, MD, MS – Harvard Medical School

Which speaks to this idea of having a registry kind of submission format that is maybe more than just an encounter, it is in fact a mechanism of submitting specific data elements.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, I think there have probably been two questions and let me get feedback, see if we can solicit feedback from SDOs on mechanisms for registry updates that are longitudinal, as well as registry updates that are for groups or panels of patients.

John Halamka, MD, MS – Harvard Medical School

Sounds good.

W

Another use case for the future would be adverse event reporting, public surveillance, you could potentially have groups of patients.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great. What are some other areas where we might want to develop comments? So, we've talked about SNOMED analogy vocabularies. We've talked a little bit about ePrescribing, transmission protocols, groups of patients. What are some other topics for which we might want to develop comments? How about the whole topic of patient access to information via the view, transport or download?

John Halamka, MD, MS – Harvard Medical School

So, that's a great topic and I know one that Dixie feels quite passionate about, because you may use Direct, I mean, I suppose you could send a Direct message from an EHR to a PHR like HealthVault, but most PHRs are going to be tethered like MyChart is tethered to Epic and there is a TLS protocol that is used quite successfully to enable a patient to look at their data or download their data, it is not Direct.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

John Halamka, MD, MS – Harvard Medical School

And so Dixie has already begun to formulate comments, guys, you know, on the patient access, you really need to say TLS alone is sufficient, but certainly welcome other comments.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, I guess one of the areas that we might want to consider commenting on is the format of the download. We actually in my organization, we have a group of 25,000 people from whom we solicit comments on these issues and we've received information that they actually would prefer what we are rolling out today, which is a CCD download, as opposed to just a free-form ASCII text download and so they can print, they can view, but at least they perceive that there are additional potential benefits of interoperability from being able to upload and use that in other systems, unlike free text. So is that an area where we might consider comments?

John Halamka, MD, MS – Harvard Medical School

And of course you have the whole blue button movement that suggests that a free text unstructured ASCII string is going to be great and sufficient and I think my feeling has always been blue button does not equate to interoperability. I mean the question of course is it's the notion of creating a webpage, I mean why even say it's free text? HTML by which a patient can view their data is of some utility, but if you really want to transmit it or download it, it makes no sense to use free text, because that free text blob is useless once you've downloaded it. And you certainly can't really do anything if you transmit it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So would we then recommend that the download should be in the consolidated CDA format?

John Halamka, MD, MS – Harvard Medical School

I would think that would be reasonable and you will have those who object. Now is the Veterans Administration on the call today?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

No, we don't have Tim or anybody from the VA.

John Halamka, MD, MS – Harvard Medical School

Because the VA said CCD is too hard, it would have taken us years, so we used free text and that allowed us to go live rapidly.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well.

John Halamka, MD, MS – Harvard Medical School

Well, okay?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I understand, but, you know, we in the same amount of time or actually less time we've actually rolled out the CCD download. So, I understand they have a big complex organization.

John Halamka, MD, MS – Harvard Medical School

Right and I was going to say, we did the same.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

M

And they're cosponsoring the OHT tooling that is focusing on CCD processing and it's very, very sophisticated tooling, we're using it in SHARP. I'm digressing, but my point is that the state of the art of the tooling that supports to generate CCD documents or CDA documents is vastly better today than it was even a year ago. And I guess I would strongly support what Jamie is proposing.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And I would add that we've done that with vendor support from multiple vendors. So I think, you know, the reality is...and, Don, if you don't mind representing the vendor community for a moment or at least your own organization, my view is that we're getting very good support for the CCD and I guess CCDA from the vendor community and so this would not be...it would just be another use of the format that they're already producing.

Donald Bechtel – Health Information Technology Standards Committee

Well, I can't speak for all the vendors, but I would concur that CCD makes a lot of sense. Use of CDA is a preferred approach for us.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So we would then recommend that as a certification requirement that patient access, in terms of download capability, should use the consolidated CDA format?

John Halamka, MD, MS – Harvard Medical School

Works for me.

Joyce Sensmeier – Health Information Technology Standards Committee

This is Joyce; I agree.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Any other comments on or any other sort of subtopics on patient access to information?

W

I just had a quick question for John Halamka. John, you talked about the TLS protocol and I have to admit ignorance of that. Just in a couple sentences could you describe what that is?

John Halamka, MD, MS – Harvard Medical School

Yes, it's HTTPS, in other words, if I go to a secure website, login and view my bank account, I am using TLS, and so given that many, many vendors will give accounts to patients to login and view, there's no Direct, there's no XDR, I mean there's nothing but your browser and you. We should probably allow that.

W

So, possibly my access to Northwestern to my portal, to my information there, would that be using TLS?

John Halamka, MD, MS – Harvard Medical School

It does in fact do that today.

W

Okay. Thank you.

John Halamka, MD, MS – Harvard Medical School

So a patient site MyChart, eClinicalWorks patient portal, I mean every one of them is just using TLS to give you access to data to view.

Donald Bechtel – Health Information Technology Standards Committee

So, Jamie, this is Don, I probably should add to my comment earlier that TLS via a patient portal would also be a preferred solution. I won't say preferred, but certainly an acceptable solution.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, so our comment then, in terms of patient access to information, we could agree with Dixie's group from the security perspective that TLS is sufficient as a transport standard for portal access, but that for download the content standard should be the CDA format? The same is as used elsewhere?

John Halamka, MD, MS – Harvard Medical School

Makes sense.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Good, okay, one more time, anything else in the patient access area for this call? I have another item I've been asked to bring up, which is a small item; it's in demographic information sets. But the comment that I received was that country of birth is arguably more important than the race and ethnicity from a clinical perspective and that there should be a required demographic data element for country of birth. And how do folks feel about potentially adding a recommendation to include a new data element in the demographic data set for country of birth?

John Halamka, MD, MS – Harvard Medical School

Such a chatty crowd today.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

John Halamka, MD, MS – Harvard Medical School

I mean, I believe we capture race, ethnicity, nationality, place of birth, but I don't think we use a structured data element.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, yeah, so nationality and place of birth would I think, you know, be, you know, fill in's for the country of birth, that's the same idea, I think.

John Halamka, MD, MS – Harvard Medical School

So, would you use some sort of ISO standard for representing a list of the world's countries in a vocabulary controlled manner?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think so.

John Halamka, MD, MS – Harvard Medical School

That would be fine with me.

Joyce Sensmeier – Health Information Technology Standards Committee

This is Joyce and I certainly have no objection.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Has anybody else heard that this could be an important item from a clinical perspective?

John Halamka, MD, MS – Harvard Medical School

I mean, I have not heard the need to have such a data element unless you were trying to deal with some tropical disease state or it's not something that typically comes up in conversation, it's more, where have you traveled recently than where you born 40 years ago?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Okay. So, I will draft something up on that. What else is there for this call? We have not yet talked about clinical decision support and I know we have some folks on the call who may have some strong feelings about that or I'm not sure, Stan, if I can call you out if you're still on the call? I think actually Stan had said he was going to have to leave at the top of the hour. But, in terms of defining, in terms of actually the definition of clinical decision support and its configuration, are there any comments that we might want to make in that area?

John Halamka, MD, MS – Harvard Medical School

This is an interesting question, so in terms of representing the rules, I mean, my sense is that decision support in the current NPRM was more of a function of what is its provenance and relevance and how do we ensure it's a good rule as opposed to do we use Arden syntax or something else to represent the rule? And at least my experience, we can welcome the input of others, I have not yet really found one leading way across the industry to represent decision support rules in a transportable fashion. You've got GLIF, you've got Arden, you've got, you know, all kinds of proprietary approaches, but I don't know if I've seen a leader.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah, and I have certainly heard some criticism of the info button standard as being essentially not something that people are using, and so the question, what it would mean for those who are doing decision support today, what's the intended scope and applicability of the info button standard?

John Halamka, MD, MS – Harvard Medical School

And where we've used info button is really on the more patient educational material side where it's I want to produce a monograph for a patient about diabetes, and I want to click a URL that goes out to Healthwise or up-to-date for somebody to retrieve that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

John Halamka, MD, MS – Harvard Medical School

But it's not decision support per se.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah. Well, maybe this is something that we can just take note of as an area for future discussion and come back to it.

John Halamka, MD, MS – Harvard Medical School

But, I may have one more tangential one for you, which is I've got a call at 1:30 today with Jonathan and Mary Jo to go over some HIT Policy Committee requests and there's a lot of swirl around family history standards, and that is, you know, sometimes I say things in my blog like "well, I actually haven't seen an implementation guide for family history and wide adoption of any particular implementation guide in any product" and I've had a dozen angry calls and e-mails about how dare I presume that family history isn't ready for prime time? So does anyone on the call know? I mean I know HL7 had a Workgroup on it. I know there's some sort of draft guidance on it. I just have never seen any implemented family history standard from HL7. Does Kaiser have codified structured family history?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

You know, I'm going to have to go back and look into that, I really am.

Christopher Chute – Mayo Foundation for Medical Education and Research

We do not, this is Chris.

John Halamka, MD, MS – Harvard Medical School

And, so the best I can say is I hear HL7 is working on it and I've never seen the product.

W

There is, XML one is not HL7, it's a government one and I'm sorry I'm really vague, but I can get some more information on it because I used it for my family. It's one that a government agency has put out and it's slipping my mind which one it is. I think it was mentioned in the Reg.

M

I think it was the Surgeon General's tool that was a high-profile a year or two back.

W

That's it.

John Halamka, MD, MS – Harvard Medical School

That's true.

W

And it's XML that connected with the Google EHR, I think or you could do that, but you could do it independently and I did do it with my family and I have it saved in an XML format. So, I don't know if they were rabble rousing about that one, but it is out there and it's being used, I can confess to that.

John Halamka, MD, MS – Harvard Medical School

Yeah, there are some contingents within government that really feel that family history is very important and I think they're looking to see...the Surgeon General's thing I agree has been used in the consumer

space, but they believe this HL7 form that has been worked on by some HL7 genomics workgroup or something is the one that we should be using and I said great, send it to me, never got it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yeah.

John Halamka, MD, MS – Harvard Medical School

The other one Farzad has been asking me about Structured Sig and I don't know are there any feelings on the call for the maturity and ready for prime timeness of Structured Sig?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I mean we certainly use electronic signature, but I believe essentially it is using proprietary vendor products.

John Halamka, MD, MS – Harvard Medical School

By Structured Sig, I mean the way when one writes a prescription and says take 10 mg tonight.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Sorry. I was thinking of electronic signature, completely different.

John Halamka, MD, MS – Harvard Medical School

Yeah.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Sorry.

John Halamka, MD, MS – Harvard Medical School

Yeah and the challenge with Structured Sig it's very hard to say, buy a 10 mg pill and break it into 2 pieces, take your prednisone taper, you know, take this 2-4 times except during allergy season when you should take it 4-6 times, all that stuff, and so imposing Structured Sig now would be early, because it would make prescription writing for many things quite hard. So although we have everything about prescribing is structured for us, the Sig field is still free text.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So, that's not in the rule, but is that something that we should make a comment on?

John Halamka, MD, MS – Harvard Medical School

Well, I guess it's just something that the folks at ONC are trying to ask themselves, is that a gap that they should have included in this rule or is that a future? And in my conversations with Doug over the weekend, I think there's general agreement it's a future. So, it doesn't necessarily necessitate a comment at this point unless you guys feel differently that Structured Sig should be moving forward now.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Okay, well I have just a few minutes left for this scheduled call, and I think what I'd like to do is ask for closing comments and then we'll go to see if there are any public comments. So, I have noted here in my notes some proposed comments that I'll do some drafting on in terms of ICD versus SNOMED for the encounter diagnosis, versus the billing classification use cases. We had a discussion on SNOMED clinical friendliness and want to support the clinician usability of SNOMED particularly when post coordinated expressions are required. We talked about discharge ePrescribing. We want to draft a recommendation there. We talked about allergy vocabularies.

We talked about transmission protocols for the different flavors of HIE including a correction in the text to add the full name of IHE specifications. We talked also about groups of patients in registry updates and potentially for adverse event reporting in the future, but essentially the need for a standard that could include groups or panels of patients as well as the need for a standard for registry update that is more broadly longitudinal.

We also talked in the area of patient access to information about TLS being sufficient for transport for portal viewing, but putting in a recommendation that the consolidated CDA format should be used for downloads when there's patient access to information. We talked about the minor demographic item about country of birth. We also started a discussion on clinical decision support that we're going to come back to next time and hopefully get some additional input on the scope and applicability of info button and make sure that that's clear in the regulation.

We talked about family history and the search for appropriate standards in family history. And then we also touched briefly on Structured Sig for prescribing and the feeling that this is not really a gap because it's premature and this would be a future item. So is there anything else from this call that we wanted to bring up, anything I missed in that summary? Okay. Then I owe you all a draft of comments from those items that I just mentioned and we'll get that out before the next call in time for reactions. And then I think we're ready for Mary Jo to see if there are any public comments?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much, Jamie. Okay, operator, would you open up the lines?

Alan Merritt – Altarum Institute

If you would like to make a public comment and your listening via you computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comments at this time.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you. Okay, Jamie?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, okay, you know, I was just reviewing my previous notes and one other item I'll put on our agenda for next time is some questions about medication reconciliation and transfers of care and how the standards might be applied there. So, I'll just leave that as an agenda item for next time, because I think we are out of time for this call. Any other comments from any other Workgroup members?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And, again, a reminder that the next call is on April 11th 12:30-1:30.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, great.

John Halamka, MD, MS – Harvard Medical School

Well thanks so much Jamie and apologies for being late, I'll be timely for the next one.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

All right, thanks everybody.

John Halamka, MD, MS – Harvard Medical School

Thank you, bye.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, bye-bye.