

Clinical Operations Workgroup
Draft Transcript
April 11, 2012

Presentation

Mary Jo Deering – Office of the National Coordinator

Good afternoon. This is Mary Jo Deering in the Office of the National Coordinator for Health IT. This is the meeting of HIT Standards Committee Clinical Operations Workgroup. It is a public call and there will be an opportunity at the end for the public to make comments. I'll begin by taking the roll. Jamie Ferguson?

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

Present.

Mary Jo Deering – Office of the National Coordinator

John Halamka? Don Bechtel?

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.

Present.

Mary Jo Deering – Office of the National Coordinator

Chris Chute? Martin Harris? Kevin Hutchinson? Liz Johnson?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Here.

Mary Jo Deering – Office of the National Coordinator

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

Joyce Sensmeier - HITSP

Present.

Mary Jo Deering – Office of the National Coordinator

Karen Trudel? Are there any other members whose names I haven't called? And would ONC staff or other staff who are on the line please identify yourselves?

Greg Staudenmaier – VHA

Hi, this is Greg Staudenmaier representing the VHA.

Elizabeth Smith – Deloitte Consulting

Hello this is Liz Smith, I'm supporting Nancy Orvis.

MacKenzie Robertson – Office of the National Coordinator

MacKenzie Robertson, ONC.

Mary Jo Deering – Office of the National Coordinator

Okay, thank you, back to you, Jamie.

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

Okay, great, thank you. So for our agenda for this meeting, we've just agreed to review the draft document that went out earlier this morning to the workgroup members from Mary Jo Deering. These are essentially the write-up of my notes from our previous calls, including this workgroup, as well as the Vocabulary Task Force, which reports to this workgroup. So I just want to first confirm that our agenda is just going to be to review those comments here among those present. Is there any need for additional agenda in this particular call?

Unidentified Speaker

No.

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

Okay, then what I'm going to ask is, now so those of you who are in workgroup should have this in your email. You may find it easier to follow this on your own screens or via a printout of the document. But I'm going to ask for, I guess, the presentation, how do we do this on the web in terms of the presentation of that document?

Caitlin Collins – Altarum Institute

I'll go ahead and pull that up right now, and I'll give you rights to move it around yourself.

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

Okay, great, thank you.

Unidentified Speaker

So, Jamie, you're just going to go to the measures where you have included comments.

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

Yes.

Mary Jo Deering – Office of the National Coordinator

Where you start on the second one or just the one that I found was on e-prescribing.

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

Yes, let me go to that.

Caitlin Collins – Altarum Institute

I see, so you should be able to scroll through that and change maximization as you see fit.

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

Okay, thank you very much. Let me see how I can. That didn't work very well. Sorry. All right, so I guess it's difficult to display this width within the window that's provided here on the screen. But the first comment is on e-prescribing. The comment is that what we discussed in the workgroup that discharge prescriptions filled by a pharmacy within the walls of a hospital facility frequently use HL-7 Version 2.X prescribing messages. However the pharmacy inside the hospital facility frequently may be in a different legal entity from the source of the discharge medication order. And so any valid HL-7 Version 2.X prescribing message should be included in certification and should be allowed for hospital discharge prescriptions when used inside a single hospital facility even if the pharmacy is in different legal entity.

So that's the write-up of my notes from my discussion. Is there any desire to change that or any disagreement with that as a workgroup comment?

Unidentified Speaker

I agree.

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

The wording is a little convoluted, but I was trying to express what I think Dr. Halamka is really describing about within the walls of the facility, you may use the same systems, but you may be in different entities.

Unidentified Speaker

Right.

Unidentified Speaker

Yes, I would agree with this.

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

Okay. And we'll go on to our next comment, which was the input that we have received from some clinicians was that country of birth or nationality should be added as a demographic data element. That it could be important in clinical care to understand the health system and the situation in which the patient growing up or experienced care before and it has been suggested by clinicians that for clinical care uses, these can be as important or more important than the race and ethnicity coding that are currently included in demographic data.

Any disagreement with this as a workgroup comment?

Unidentified Speaker

My only concern was I thought I heard in the last call that the concern expressed or the suggestion made, I'm not sure which it was, that ethnicity be removed, but maybe this is a different call and as long as this is an additional suggestion.

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

Right, this would be in addition. I didn't have any notes about—

Unidentified Speaker

Jamie, I'm on ... group, so forgive me if I've misrepresented what got discussed here.

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

Okay.

Unidentified Speaker

But this looks fine.

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

Yes, and actually I'm not sure if it's race or ethnicity, but one of those essentially the coding system that's used says Hispanic versus non-Hispanic.

Unidentified Speaker

I can't remember which one it is, but that is the code set, so that's all the information you get.

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

Yes, and so this idea of country of birth or nationality would be an additional suggestion.

Unidentified Speaker

Do we have a code set for that, Jamie today?

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

You know I didn't do the research myself to understand what code sets, I'm confident that there are code sets that are used by federal agencies for nationality, but I just don't know what they are.

Unidentified Speaker

Okay, but it could be something that we could do. It would not be go to the pointed piece of paper and start there. We could take it advantage of other industry's use.

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

Well, should we suggest, make a particular suggestion? My thinking was that coding systems that are already used in federal government efforts, whether it's by the State Department or for some other purpose could be used here.

Unidentified Speaker

That would be my hope. Anybody else? I just want to make sure that we can take advantage of something that's already in existence for lots of reasons, one of them being harmonization not starting again.

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

Okay, so the way I'm capturing that then is that we would amend the comment to say we want to use a coding system that's already been deployed, but do you want to say in the federal program or not?

Unidentified Speaker

I don't know if we want to limit it, but that's the only immediate one that comes to mind I think would be we'd had enough testing and time and implementation to be valid, but I hadn't thought about it.

Joyce Sensmeier – HITSP

...standardized format in a standardized format.

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

Yes, thank you.

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

Okay, excellent, thank you. I think we have that one.

Let me go down now to our next workgroup comment here. We did have a brief discussion on the clinical decision support. We wanted to come back to this, but what I captured from the previous discussion was a sense that the Info Button is sort of mischaracterized as a decision support intervention, and that this is a way of referencing information, which is very useful and making that information available to the clinician user is a good thing. So we're not saying Info Button is a good thing, but it's not in the same class of clinical decision support interventions as an alert or a reminder or something that can be configured that requires a user to take action, so that was the basis of this comment, which says HL-7 info button is a useful standard for information retrieval. It should be required in certification. However, simple web links should be added to certification, and also should be able to be used for information retrieval. Enabling information retrieval and linked references while important should not be classified as a clinical decision support intervention alongside intervention, such as an alert or a reminder. A key distinction is for EHR technology to have the ability to enable a user to act e.g. to retrieve information versus having the ability to require a user to act e.g. to click through an alert or a reminder.

So the one thing in my preference that I left out was the suggestion from Dr. Halamka that simple web links should be added as a perfectly acceptable mechanism for information retrieval and not always having to use Info Button.

Mary Jo Deering – Office of the National Coordinator

One of the things that came up in the patient engagement group is to make this Info Button concept for information only, so you described it very well available to the patient, an interesting concept.

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

Yes, and so there's certainly nothing wrong with that, but again, so this would say that where Info Button is a useful standard, there can be cases where you could just embed a web link and not have to actually use Info Button. So I don't think there's any conflict with that, do you?

Mary Jo Deering – Office of the National Coordinator

No, I do not.

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

Okay, any changes to this comment, this recommended comment?

Unidentified Speaker

I have no changes.

Unidentified Speaker

No.

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

All right, thank you. Okay, our next comment is about the patient download capability. What we had agreed to say was that it should be required to use consolidated CDA. The comment says, "This format can meet the requirements for individual empowerment i.e. to enable individuals to print, view and store their information while at the same time its use advances interoperability by also enabling incorporation of discreet structured data into other systems in useful ways in simple free text, e.g. blue button cannot."

Does that capture our discussion appropriately?

Unidentified Speaker

Jamie I don't know if this is appropriate or not, we had a long and a long discussion this morning on the implementation workgroup about HR-7 CCDA, C-32 versus HITSP and there are minor differences. What are you suggesting here?

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

This is saying the CCDA.

Unidentified Speaker

Okay.

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

It's just saying use CCDA for this purpose period.

Unidentified Speaker

That's all it's saying, okay.

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

Yes.

Unidentified Speaker

Okay.

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

But this is also saying I think the essence of this is whatever is chosen as the primary mechanism for a structured summary use that and I think we were assuming that's going to be the CCDA. We're saying don't just use free text.

Unidentified Speaker

Right, right, that's the heart of it.

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

Yes.

Unidentified Speaker

I agree this represents our discussion.

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

Okay, okay, good. The second point on this topic is the one, Joyce, that you had brought up, the citation for XDM and XDR should refer to IAG XDM and IAG XDR.

Joyce Sensmeier – HITSP

Yes.

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

And then the third one is that for transport you shouldn't only require direct. You should also allow a simple TLS HTTPS to be added as a certification requirement and in the case of the portal use case in particular should be sufficient.

Unidentified Speaker

So, Jamie, when you say it that way, it becomes an or, right, it could be this or direct?

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

That's correct, that's correct.

Unidentified Speaker

Okay, thank you.

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

Should that be clarified here?

Unidentified Speaker

The only reason, I think it's clear. I read it that way, but I want it to be very clear to them.

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

Okay, so—

Unidentified Speaker

I don't know if—

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

No, so I'll amend the comment to say it should be in addition to.

Unidentified Speaker

Right, please.

Unidentified Speaker

So in addition to the same as an or?

Unidentified Speaker

Yes.

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

Yes, it is.

Unidentified Speaker

That's a good question.

Unidentified Speaker

I was thinking of that as an and.

Unidentified Speaker

Yes.

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

It's an and for the vendor and it's an or for the user.

Unidentified Speaker

Yes.

Unidentified Speaker

Okay.

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

Right, so in order for it to be an or for the user, it has to be an and for the certification.

Unidentified Speaker

Yes.

Unidentified Speaker

I'm with you.

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

Which is actually consistent, sort of logically consistent with what we said on transports for the other purposes as well, which I will now scroll down to. Okay, but I guess the next thing was about the really the consolidated CDA and the summary and what's in it. Now this actually encapsulates a set of recommendations from the Vocabulary Task Force, which has a call primarily on this exact topic last week. So this is now suggested as a workgroup comment from the Vocabulary Task Force. So we're saying RxNORM has matured substantially and should be used to the extent possible for medication related terminology, including generic drugs, drug classes, active and inactive ingredients. Allergy vocabulary should use the RxNORM, RxCUI identifiers for ingredient allergies and drug class instead of UNII, the Unique National Ingredient Identifier and the VA's NDF-RT.

So the basis of that, just to explain the basis of that recommendation is that UNII and NDF-RT are now completely incorporated in and fully represented in RxNORM. So you can either use essentially the UNII identifier for the concept or the ingredient, or you can use the RXCUI identifier for the identical ingredient. And what we were after was parsimony in terms of the representation of the format of both drugs, drug classes, and active and inactive ingredients, so that essentially we would use just the RXCUI identifiers for everything that's in RxNORM, so that's this general recommendation.

Unidentified Speaker

So in terms of ... substantially, what is the penetration of this in our vendor software today? Is this going to be a big step up and will we get there in time? Does it mean we change our recommendation or it's more of a clarification for do-ability so to speak.

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

Let me ask Don to comment on that, I guess. I guess I would also point out that RxNORM/RxCUIs are already used for other things, basically for drug identification. This is just saying use the same format for the concept identifiers for ingredients and drug classes for allergies. But, Don, do you think that represents a problem or Joyce for vendors?

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.

I honestly can't speak for everyone, but I don't think so.

Unidentified Speaker

Okay, it's the right thing to do and if we're market-wise already, then we should be doing it.

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

Yes.

Unidentified Speaker

Yes.

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

It actually seems like it's a simplification using the same format, but maybe that is a complication for somebody.

Unidentified Speaker

Yes.

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

Okay, the second recommendation again from the Vocabulary Task Force was that encountered diagnosis should adopt SNOMED CT instead of ICD-10. We had asked for clarification from ONC staff who pointed us back to the preamble to the proposed rule, which indicated that the intent really was to capture and represent data primarily for clinical purposes. So this really was intended to be the clinical diagnosis where clinical accuracy was paramount and where the vocabulary group felt that SNOMED CT is most appropriate, as opposed to billing classification purposes and other administrative purposes where ICD-10 would be most appropriate. But since the intent here is really for clinical use, then the encountered diagnosis here should use SNOMED. So how do folks on the call feel about that?

Unidentified Speaker

I concur, others?

Unidentified Speaker

Yes, I think that was the intent of our discussion last time, so I do—

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

Right, right, in this clinical ops workgroup, we basically said that, but we also kicked it back to the vocabulary group. They reviewed it and said absolutely.

Now there is another part of the discussion that we had that also happened in the vocabulary group that is not a comment here in the recommendation. We can consider adding it, but that comment is that if a billing classification and billing use case is also intended to be fulfilled here, then an additional data element should be added for the billing classification where ICD -10 would be the appropriate vocabulary.

Unidentified Speaker

Right.

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

But I guess in the vocabulary group, there was some feeling that that could potentially be confusing or that that could be out of scope, and so that's why it didn't make it into the comments coming out of that group.

Unidentified Speaker

So are we going to be silent on that then, Jamie?

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

Well, that's really the question I think, so the way it stands right now is we're just saying for the encounter diagnosis to the use for clinical purposes use SNOMED period, and not going off into the hypothetical of if you also want a billing classification, then you use ICD.

Unidentified Speaker

Since we're the clinical operations group that's probably safe territory for us.

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

Okay. Then are there any other comments on that one? No, then the last comment here is that, and this again was a recommendation from the Vocabulary Task Force was that, and it's not really for the NPRM, this is really a comment to ONC about the implementation of this, and that is that a program of education and outreach should inform potential meaningful users, as well as vendors seeking certification for their products of the availability of vocabulary resources specifically including cross-maps from the National Library of Medicine between SNOMED and ICD. They have one actually from ICD-9 to SNOMED and they have one that's published along with an online toolset from SNOMED to ICD-10, as well as vocabulary subsets and value sets, particularly value sets for measures. So the availability of those resources should be highlighted. It doesn't say they have to be used.

Unidentified Speaker

So I like that a lot and I think that's very important. Does this stop short of the concept that we discussed at one point, Jamie, where it was the one stop shop for standards, etc?

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

Well, yes, I think this points to the availability of the resources that are out there, and then if the way that we previously recommended to get there was by having a one stop shop, we don't quite have a one stop shop yet.

Unidentified Speaker

Right, but at least we've got this concept out there and the importance of it, I like that. A lot of politics in the other that you probably

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

Then going on to the next comment, this again, was the idea that in addition to using the Info Button, simple web links should be required in certification and should be allowed to be used to meet the requirements, so again, this is an and for those who are developing the technology, which makes it an or for the user.

Unidentified Speaker

Would that concept in talking with the workgroup, the concept probably crosses over several areas and are you naming them to the specific—all I'm thinking about is a different life where I was looking at testing procedures and how many times—I am all for the concept. I don't know if we want to regulate where you have to do it and we may or if we want to regulate that that capability is available.

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

This particular comment is on the using certified EHR technology to identify patient specific education resources and provide those resources to the patient, so this is essentially saying be more permissive and just allow the use of web links in addition to Info Button.

Unidentified Speaker

Okay. So when we get there, okay, because we will have the resources, there's a resource measure as well, an educational resource measure as well. Okay, I'm with you.

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

All right, okay. Okay.

Unidentified Speaker

And there it is, okay. I'm sorry, maybe you had already moved to 13 and I was behind. I apologize.

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

Oh, yes.

Unidentified Speaker

I'm with you now on ..., that's why I said there is one when you're thinking yes, we're on it. You're behind.

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

Right. So that's what I was just saying. So I've been jumping around perhaps a little bit and I'm not sure how it updates on everybody's screen. So we're now on item 15, which was the medication reconciliation and transfers of care. So some concern was expressed about merging data and the need for appropriate validation steps. So this is the item that at the top of the call I had suggested we might not have the right stakeholder representation of workgroup members on this call to go into this in more detail. This is also something that I think Dr. Halamka had wanted to participate, and he's not on the call today, neither is I think Stan Huff and Chris Chute also had expressed an interest in discussing this. So what I'd like to do is defer this to a next call yet to be scheduled.

Unidentified Speaker

Perfect.

Unidentified Speaker

Will we do the same thing with eMAR, Jamie?

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

Yes, this is, yes... is this EMAR? Yes, so clinical information, reconciliation—

Unidentified Speaker

This is med, yes.

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

Med reconciliation.

Unidentified Speaker

Yes, and then we have EMAR separately.

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

Okay. And now we get into number 16, which is clinical information sharing for transitions of care. So the first comment just reflects our discussions at consolidated PDAs is a great step in the right direction and is strongly supported by the workgroup. But then we went on to say that different transmission protocols best fit different communities, different providers, or patients, or different transfer of care scenarios. And therefore eligible professionals and hospitals should not be required to use any particular transmission protocols for purposes of the meaningful use measure. Instead they could be required to demonstrate the ability to use certified EHR technology to transmit consolidated CDA perhaps attesting to a single successful test message with standard data content. However in the clinical care process, they should be free to use the technology that best fits the needs of the patient and the care team.

This also should allow the use of proprietary vendor exchange mechanisms for purposes of meeting the measure, so long as providers have successfully demonstrated the ability to use the standards that are enabled by their certified technology. So this is the big discussion that we had about, and actually let me just read the other points that I think go along with this.

So the next sub bullet says, "For transport both S/MIME, SMTP and SOAP should be required equally in certified EHR technology." The next one says, "The SOAP standards reference is particularly obscure and regulations should be clarified to require both direct S/MIME, SMTP and NwHIN Exchange SOAP protocol specifications as equally required." And the finally the standards citation again should refer to IHE-XDM and IHE-XDR. So this was something we had a big conversation about essentially saying that both the point-to-point push of direct, as well as query response and other mechanisms that are enabled by the NwHIN Exchange should be equally required to be present in the technology, and then let the provider choose what best fits the patient care scenario instead of requiring the use of a particular

protocol to meet the measure. So that was the gist of our conversation, and I'd love to get input or confirmation on that.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.

Jamie, this is Don. This rings true to what I recall from the meeting.

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

Okay. Joyce or Liz, how do you feel about this?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Let me read this one more time. I may have a question or two just hang on a second.

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

Okay.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

On the last sentence of number two, I just want to clarify what I'm reading. This also should allow the use for proprietary vendor exchange mechanisms as long as we've demonstrated the ability to use it through certified. Does that imply that the proprietary vendor exchange mechanisms are not certified?

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

That's correct.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Okay.

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

I think that's right. I hadn't really thought about that.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

That's what I'm reading and I'm not objecting to it. I don't know that that meets the intent of the NPRM. It is what we want.

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

Well, yes, that was the gist of our conversation was that so if you're in a scenario where direct is the best thing for connecting with another provider, then you should use direct. If you're in a scenario where the NwHIN Exchange mechanisms are used by the other providers, then you should use those. But if you're in a community where everybody in the community has the same vendor and the vendor propriety mechanism that's non-standard actually has better functionality, then you should use that for patient care. But you can't ignore the standards, so that's why the recommendation says you have to demonstrate an ability to actually use the standards. So that if you're in a situation where that's the best thing for the patient, you can do that.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

The local solution as you described it does have to be certified, yes or no? That's where I'm struggling. Is that a transport mechanism or is that a modular piece of the solution that, because it's not part of the base CHR, but it is part of the CEA part.

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

My thinking, and maybe Don or Joyce could speak to this, my thinking was that the use of the standards is certified, but the vendor may also have capabilities that are not certified.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

True, so we're not limiting the functionality of the vendor. Are they certified at all is what I'm asking.

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

I think yes.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Okay.

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

So I think what this is trying to say is that the vendor should be required to be certified to both direct and exchange mechanisms equally.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Right.

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

That the providers should be required to have implemented at least one of those standards, if not both of them, but at least one of those standards, and at least attest or demonstrate that they can use the standards.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

But not be limited to that set of functionalities.

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

But not limited to that. If they've got something that's non-standard that's actually better for patient care, they should be able to use it.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Right, okay.

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

But maybe this doesn't say that. I don't know. How could it be improved?

Unidentified Speaker

That's what I was just thinking, so we've done a lot of explaining of that one sentence.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Yes, I think that's always the quandary is when you hand this over to somebody else that they weren't meeting an EL notice, would they get your point?

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

So how about just again, amending this by adding on further explanation at the end saying this means that vendors would have to certify to both standards, that providers would have to have implemented at least one standard, but that they should not be limited to the standard in clinical care.

Joyce Sensmeier – HITSP

Right.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Yes, that sounds better.

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

Would you just add that at the end, is that okay?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

Yes, I think so.

Unidentified Speaker

Yes, I agree.

Unidentified Speaker

That's fair.

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

Okay. Let me just write that down real quick here. Let me also just ask for comments on the rest of this.

Unidentified Speaker

I think the comments on some of this are just clarifying what an ... certified, too, isn't that correct?

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

Okay. I think I've got that now, so let's see what else we have in here. I'm not sure, what else did we have?

Unidentified Speaker

Do you have the immunization one, individual this versus that on line 17?

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

Where is that, okay, 17, all right, I skipped right by that.

Unidentified Speaker

My only question there was, so this is probably because I didn't look at the standard, I didn't open up the standard while we were talking. I didn't understand, I may be telling on myself, because we are doing batches now, is the standards... the individual?

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

The standard is an update that identifies an individual patient, but the idea was that a different standard might be useful for lists for patients or perhaps an implementation guide for how to do lists of patients more effectively could be useful.

Unidentified Speaker

Okay. We have to capture it by patient, there's no question for lots of a dozen reasons, but okay.

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

Right.

Unidentified Speaker

I got you.

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

But this was also a comment that came in from I think the health plan perspective in addition to the public health perspective of having a well understood implementation guide for listed patients.

Unidentified Speaker

Yes, which is a good idea all the way around.

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

So maybe instead of talking about this as a standard, maybe it's really more about having an implementation guide.

Unidentified Speaker

Yes.

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

Okay, and so I think that's actually that's it. Is there anything else that we need to discuss on this call?

Unidentified Speaker

You did a nice job of consolidating all this, Jamie.

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

Thank you. So just in terms of next steps, the Vocabulary Task Force is scheduling another call to talk about post coordination in SNOMED. There are really three aspects of that. One is how it's used in e-measures, how a post coordination either is or is not considered in usability for clinicians where, for example, the problem list concept requires post coordination in SNOMED, how to make that usable for clinicians and how to deal with that in a standardized way. And then the third item is on post coordination is its representation for interoperability and ensuring that we have standardized representation of post coordinated concepts in, for example, the consolidated CDA.

So that's on the Vocabulary Task Force and then for this workgroup itself, I think that, again, the two items that we want to cover in a future call are really about medication reconciliation including EMAR, as well as a further discussion on clinical decision support.

Unidentified Speaker

It sounds good.

Unidentified Speaker

Very good.

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

All right and so we'll try to get that scheduled absolutely as quickly as possible. I think with that, Mary Jo, I think we're ready for any public comment.

Mary Jo Deering – Office of the National Coordinator

Thanks very much, Jamie. Okay, operator, would you open the lines, please?

Operator

(Instructions given.) We do not have any comment at this time.

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

Okay.

Unidentified Speaker

Okay, Jamie, we will get this other call scheduled as soon as we can.

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

Okay, thank you so much. Thanks to everyone who joined this call. I really appreciate your time.

Mary Jo Deering – Office of the National Coordinator

All right, talk to you later, thank you.

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

Okay, thank you.

Mary Jo Deering – Office of the National Coordinator

Bye, bye.