

**NwHIN Power Team**  
**Draft Transcript**  
**June 5, 2012**

## **Presentation**

### **Operator**

All lines are now bridged.

### **MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Nationwide Health Information Network Power Team. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please make sure you identify yourself before speaking. I will go through roll and ask for any staff members on the line to also identify themselves. Dixie Baker, who is unable to attend today. Tim Cromwell? Floyd Eisenberg? Ollie Gray? David Groves? Arien Malec? David McCallie?

### **David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, David. Nancy Orvis? Marc Overhage?

### **Marc Overhage – Siemens Healthcare**

Present.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Marc. Wes Rishel? Cris Ross?

### **Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thank you, Cris. Are there any staff members on the line?

### **Matthew Rahn – Office of the National Coordinator**

Yes, this is Matthew Rahn with ONC.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Matt.

### **Ellen Lengermann – Office of the National Coordinator**

This is Ellen Lengermann with ONC.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Ellen. Okay, David, I will turn it over to you.

### **David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Thank you, MacKenzie, and welcome to the public and to the NwHIN Power Team Workgroup. Dixie is out this week and she asked me to fill her tiny but incredibly effective shoes and run today's call, so we're going to pick up where we left off in the previous call and work our way through as many questions as we can get through.

I believe on the screen you should see the first question that we were going to address, which is, what, 63?

**Matthew Rahn – Office of the National Coordinator**

Sorry, I'm having technical difficulties here. I tried using a new computer because mine kept freezing last time. Hold on.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

You're tempting the demo gods if you do that.

**Matthew Rahn – Office of the National Coordinator**

I know, seriously. Hold on. It should be back in here in a second. Can you see it, is it big enough?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

That's better.

**MacKenzie Robertson – Office of the National Coordinator**

Yes.

**Matthew Rahn – Office of the National Coordinator**

But it's usually my full screen. Oh well.

**MacKenzie Robertson – Office of the National Coordinator**

I think it's starting to upload now to your screen.

**Matthew Rahn – Office of the National Coordinator**

Okay, here we go. There we go. That looks a lot better.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Good. So as any of you present on the last call will recall we never really finished question 63, although I think it was Tim Cromwell who had some thoughts about it. I don't believe he's on our call yet, so we may have to finish in his place. The question is, what would be the best way for the ONC to help facilitate the pilot testing and learning necessary for implementing technical standards in implementation specifications categorized as emerging or pilot? And I think the context of this that was informing our discussion last time was the awareness that in the past some of the protocols that had been put forward as part of NwHIN pilot experiments have, maybe a polite way to put it, is not finished or have not really been fully thought through from a scalability point of view and a belief that maybe Tim's sentiments, and I hate to put words in his mouth, but his sentiment may have been that the ONC could have facilitated the process a little further before it was turned loose for piloting. And I think we had captured here a thought that the validating bodies should encourage the ONC to take a role in this process, but I don't believe we really said anything more precise than that.

Let me stop talking and see if you guys have different recollections of the discussion or want to take it in a different direction. Cris or Marc, do either of you have any thoughts? I think the notion here is that we have this framework for evaluating potential protocols, which is a step beyond what we had in the past, and that framework is still fairly abstract and wouldn't necessarily guarantee that a protocol in pilot, ready for pilot, would actually work in pilot. And I think the broad question is, should the ONC have a more formal process in evaluating protocols for their candidate use, or should that be left to the validation bodies, which is certainly I think the other option.

**M**

When you said would we take this another way, I just froze thinking, well, what other way can we go, saying validation body helps. If Wes were here I think he would talk about his concern about, what did he call it, bidirectional asynchronicity?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, yes.

**M**

And I think he would make the point that whoever is responsible for this ought to include as an explicit part of its plan the ability to test not just for compatibility with the existing standards and implementation specifications, but also the compatibility upwards and downwards between a limited set of versions, to be described in some reasonable way.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, so a friendly amendment to that would be for those protocols where versioning makes sense, that one of the criteria to be considered ought to include the ability to be both backward and forward compatible as the protocol is adopted gradually through a community. And my concern is that not every protocol may fit that model, probably most of them do, but there may be, for example, a security bug that is so egregious that it really is a mandatory, immediate upgrade, and that might be something that one has to enforce with something other than a gradual backward compatibility model; you might actually exclude ... from the network until they fix it.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

If this focus is on implementing technical standards and implementation specifications categorized as emerging or pilot, I can speak a little bit from Surescripts' experience that once the NCPDP script standard is adopted, Surescripts, acting in the role of an NVE, will in fact turn off a vendor or even a pharmacy or PBM that has a problem with implementation of some feature, if it's causing a risk problem it's shut off rather quickly. And the same thing happens in clearinghouses for claim transmission purposes. When we went from 4010 to 5010 those responsible for X12 transactions would have to test that each of its participants met some standard. You would think that the NVEs have a place in this, you would think that the validating entities would provide at least some form of standard that an NVE must use in its operations, so I guess the question is, is there a role, above and beyond that for ONC or someone else, to deal with emerging or pilot specs?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I can imagine maybe the context of this question could include reflecting on the pilot work that was done with direct under ONC's sponsorship, so quite clearly the direct project didn't stop with the statement of the protocol to be used, it didn't stop with the release of open source, source code to play with, it actually pushed all the way to a significant number of regional pilots. And I think that was useful. I think quite a bit was learned in that, so I'm guessing the question might be should there be some process where that could be repeated in the future by ONC and I think that makes sense to me, although I wouldn't say that it has to happen that way. I could imagine protocols coming in through different routes that have been validated in other ways that could be perfectly acceptable to become part of the framework, the NVE framework. Cris, how did NCPDP get validated? That was done privately, wasn't it?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes. NCPDP acts as a standards development organization and it has certain authorization under the Medicare Modernization Act that gives it both statutory and regulatory authority. In that way it's not about emerging standards, but NCPDP, just like every other SDO, just like HL7, does the work of introducing new ones in pilot fashion and all the rest. Am I answering your question? I'm not sure if I am.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think so. In other words, I think saying something that the ONC should be willing to step in and facilitate pilot testing of candidate protocols that are not otherwise being appropriately tested by other bodies. What I'm trying to say I think is that there may be a need for the ONC but it wouldn't be a part of the formal process that it has to go through an ONC pilot.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Does that make sense? In other words we could adopt something from the outside world that has been pretty thoroughly validated already and it gets blessed and added as a CTE for those NVEs that need it, and the ONC doesn't really have to do very much. On the other hand, a new emergent protocol that looks good on paper but has never been tested may be a good place for ONC to step up and facilitate a pilot test.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right, that makes sense.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So the language that Matthew's put in is: "ONC should be willing to step in and test candidate protocols that are otherwise not tested by other bodies." I think that's capturing what we're saying here.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Do we want to specify other bodies like SDOs or validating entities?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes. I'm hesitant to use the word "SDO" for fear that that implies a certain anti hierarchy or something and I think these things could come out of IETF, they could come out of W3C, they could come out of private industry, where the industry donates a protocol. They could come out of something like SNTP, where it's just out there. It goes way back to some entity that probably doesn't even exist anymore.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So I'm not sure what words to use there. "Not tested by other" – how about, Matthew, if it read something like: "Willing to step in and test candidate protocols that have not otherwise been properly tested by existing standards organizations or other protocol supporting bodies." That's really cumbersome language. How about just "other protocol entities"? I think entities or bodies is okay. We're not writing regulations here, we're just –

**M**

Right, right. Good point.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I'm happy with that. Are you guys okay with that?

**M**

Yes.

**M**

Do you guys think the sentence is right, the one before it?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

"For those protocols where aversion makes sense one criteria" – how about "an important criteria to consider is that there be backward and forward compatibility"?

**M**

Thank you. That's good.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I'm reticent to lock that in as a requirement, ... automatically.

**Marc Overhage – Siemens Healthcare**

The other thing that strikes me in thinking about what ONC can do is it seems that, I don't know how to say this very well, but where I'm headed is if somebody has an idea or direction or something one of the things that is a barrier is if they're not confident that they know what criteria they need to meet or what they need to achieve in order to go forward, so transparency of criteria or something like that that will be used to evaluate will be important here, because people are going to invest a lot of energy if they feel uncertain about what they have to do.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes. One thing is our framework of course ... that this workgroup is supposedly working on –

**Marc Overhage – Siemens Healthcare**

I would try not to be self-serving.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, and that will obviously be transparent because it's public work.

**Marc Overhage – Siemens Healthcare**

Right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

But I think maybe, Marc, some of that question might come out in the next two –

**Marc Overhage – Siemens Healthcare**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

... so let's go to 64 and see if we can work that notion in here. Question 64 is, would this approach for classifying technical standards and implementation specifications be effective for updating and refreshing interoperability CTEs? And I'm a little bit ambiguous as to what this approach is referring to. I guess is that the answer to our question 63, is that what they mean by this approach, or do they mean our NwHIN framework? How about if we assume it's the NwHIN framework, and let me just put a straw man on the table and say the NwHIN Power Team framework is a useful start at classifying technical standards and implementation specifications, but we suggest that the validating bodies who take responsibility for those standards may do deeper refinement. Does that make sense? Where I'm headed with that idea is that the validating bodies, it seems like to me the way we've been thinking about this is there may be validating bodies that focus in on specific interoperability protocols, for example, DirectTrust.org is going to focus on direct, and Exchange.org is going to focus on exchange. Those would be the places for refining their protocols.

**M**

David, I didn't get the second part.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

NwHIN Power Team approaches a start for classifying technical standards and implementation specifications – oh boy, what did I say – but additional specificity may be added by the validating bodies that plan to certify the actual protocols.

**M**

So sometimes when I get stuck on these I've been going back to the RFI itself – and I'm sorry, I don't mean to interrupt, if you guys are still wordsmithing. I'm sorry. Why don't you –

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

No, no, go ahead.

**M**

... finish that. The thing that's interesting about these questions is that they're not related to a condition in the way that other ones are. This is related to the materials on page 58 and further, this is around a CTE life cycle fundamentally, and there's no particular CTE or condition that we're supposed to comment on, so I think we're on the right track, but I think we should just keep in mind that these sets of questions are all pure process questions and not so much content questions, right?

**Matthew Rahn – Office of the National Coordinator**

David, this is Matt. That question is specifically related to the emerging standards pilot, the national standards.

**M**

Yes, which is on page 62 of the RFI, right?

**Matthew Rahn – Office of the National Coordinator**

Yes.

**M**

So there's some commentary in here around the role of the Policy Committee and the Standards Committee that – I don't want to blow up what we're talking about, but I think we might be missing the context of the RFI.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, and I think you're probably right. I don't, unfortunately, have that language in front of me, but the –

**M**

Do you want me to e-mail you the RFI?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Oh, I have it somewhere.

**M**

It's easy enough. I'll send it to you right now so it will be at the top of your –

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

That might be the quickest way to find it, because I have it buried in a directory.

**M**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

... things. So an example might be, let's say this RESTful protocol, there are a number of RESTful protocols being worked on, but let's pick one of them that emerges and actually solves real problems and would be generally perceived to be an improvement over what we have, it either adds new value, or it reduces complexity, or it scales better, for some reason it looks good. Maybe the question here is how does that protocol get into the CTE status, how does ... CTE, is that how you see it, Cris?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I think that is the general theme of that set of questions, yes. Specifically, this one is talking about life cycle for emerging. It's not life cycle of emerge, mature, and sunset. This is literally just how do we get from emerging into national standards, and on this diagram the axes are adoptability and maturity, which is pretty similar to the framework, if not identical to the framework, that the NwHIN Power Team came up with in our work when we were doing the compare and contrast between direct and exchange, right, and other protocols.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

We've got a framework that someone with the appropriate authority could actually qualify or even quantify a new protocol, but there is a process defined that says it's blessed and so this question is really what should that process be, is that how you read it?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

One candidate is that the ONC HIT Standards Committee has to formally endorse the protocol; another approach is it has to come through a validated SDO, and another approach is it has to just meet the business case of a validating body who wants to propose it as a CTE. I'm not sure where to go with this. ... too restrictive.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, so the RFI specifically, just looking at the text, is they're proposing earlier an annual process to identify, review, and assess standards and implementation specifications, "We assume a discrete set of objective criteria be necessary to assess whether and when a technical standard implementation specification should be classified differently." It then says, "The Policy Committee would have a key role in prioritizing standards and specs, the Standards Committee an integral role in advising ONC about how to classify such technical standards and implementation specs. The Standards Committee has had initial discussions on what classification criteria should look like, such as maturity, market adoption, need deployment," da da da, which is NwHIN Power Team stuff. So I think this question is specifically asking us are we okay with the idea of an annual process in general where the Policy Committee prioritizes standards implementation specs and Standards Committee advises ONC about how to classify them. And I think we're also being asked to comment on essentially our own work, this work team's work, the initial discussions on what the classification criteria could look like.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, so one answer might be we endorse the framework outlined in the RFI on page 62.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Which I think is a good framework. My only concern is that it not become too restrictive – well, maybe it should be. I don't know how ONC in a regulatory role is responsible for the introduction of a new protocol that might in some way shift the balance of an existing set of NVE players. Maybe it has to go through ONC's hands before it can really become part of the NwHIN, in which case the FACAs are a good start. But would it go through the FACAs to regulation?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

That is where I was going next. I think we've heard before, in Meaningful Use 1 there were places where we wanted to delegate some things to a standards development organization, or we wanted to say specification 2.x, and I think our guidance was that we couldn't do that, that the regulation had to be particular. I assume that that means that.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, so I'm open to suggestions. I think that the text outlined on the RFI on page 62 describes pretty accurately the way we have envisioned it working with roles for the Policy Committee, the Standards Committee, and this framework that we are developing.

**Ellen Lengermann – Office of the National Coordinator**

Hi. I just have a question. Question 64 says something about at the end is this approach effective for ... and refreshing interoperability ...? Are we answering that part of the question, that this framework would inform or be effective for updating and refreshing the interoperability of CTEs?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I don't think so. We're really describing the emerging or pilot. That's a good clarifying question. These are pretty vaguely written. Our framework does not address identifying a profile that is in need of update. I don't think anything described on page 62 is really particularly relevant for that other than that the Policy Committee may identify that there's a policy priority to improve something that isn't working well. Cris or Marc, do either of you have any thoughts about that?

**Marc Overhage – Siemens Healthcare**

No, not beyond what you said.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Cris, how does NCPDP decide when it's time to improve the standard?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Oh boy, I'm not a delegate to NCPDP, nor an expert, but observing it secondhand my understanding is that there's a need that arises from industry or there's some imperative that comes along because of a regulation, either a state or a federal regulation, and when that problem is addressed, either an opportunity or a problem, someone can bring it to that body for consideration.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

How about something to the effect, what if we said something that "It is likely that awareness of the need for updating and refreshing is likely to emerge from the NVEs through their validating body."

**Marc Overhage – Siemens Healthcare**

I think that's pretty close, David.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So in other words, once a protocol is out and in place and in use, awareness of its shortcomings is most likely to arise from the NVEs who are using it and the validating bodies who are certifying against it, and that that's a likely route for identification of the need to update or refresh a CTE.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, in this context, I'm just looking at the document, about what's the precedents that are included here. I'm sorry for the pause. I'm just trying to read ahead. I think the expectation here is that someone would submit emerging best standards and so on to ONC, directly or through an advisory committee. There was also a suggestion that validation bodies might provide, for validation of a pilot, CTEs that could inform this, but I think there's no identification here, ONC is not suggesting a role for SDOs. I think in the RFI ONC is suggesting that it and the advisory committees would be the place to set priorities and so on with a potential role of validating entities to pilot some CTEs. I guess I'm just trying to direct, I guess back to the RFI language specifically that I think we're being asked to comment on.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

And you see this as an answer to which question?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well, there's some preamble material, right, that begins in the middle of page 56 that talks about the idea of how this would work, and then there's a bunch of nested questions. And then on the bottom of page 58 there's this notion about a CTE life cycle that I think specifically informs questions 60 through 65, the ones we're working on right now. So I think there's this idea of the comment, "We believe that it would benefit the industry to include as part of the governance mechanism a formal and transparent process to classify technical standards and implementation specifications that could ultimately be adopted within the interoperability category of CTEs, that processing formed by priorities set by ONC based on recommendations of policy standards through an annual review and assessment process." In some ways I think it sounds like the Policy Committee and Standards Committee are still to use a process to identify emerging pilot and national standards and that ONC would observe those regulations and then have some form of process where this is written in a passive voice but somehow the industry and ONC are supposed to have a formal and transparent process for this, but we haven't identified what the venue is for that specifically. If I'm taking us on a tangent I apologize. I'm literally just trying to interpret the RFI so we can answer these questions precisely.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

No, I think you're exactly right. That's the context of the questions. I'm just not sure how to specify succinct answers to something that's a pretty complicated process.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Especially when there's no active voice character who's supposed to do – it's sort of like, well, the Policy Committee and the Standards Committee and ONC together will somehow drive this, but there's no notion about, okay, where's the venue, who decides, is this an SDO activity or is this a regulatory activity. It feels like it's a little mushy.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, I think it is mushy, as is the whole RFI. It's open-ended and hopefully designed to elicit good ideas.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So candidates to be the driving active voice could be delegated to ONC's Chief of Interoperability, could be devolved to the S&I framework. It's not quite clear to me how the S&I framework decides what to take up. They seem to announce new ones fairly frequently.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Fair point.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So I don't know. I like the language in the RFI to describe this process, it's flexible, it's not too bound to specific entities, but that's probably not sufficient to write a regulation.

**Marc Overhage – Siemens Healthcare**

David, maybe we should just put a comma on this one and move on, ... great ideas.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think our simple things that we believe that the description in the RFI is a good framework against which to refine a regulatory process.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, if I can offer any sort of comment for us to come back to it would be our observation that the process seems like it makes sense, but the parties and roles are not very clearly defined in the RFI text.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And that in order for this good idea to actually work you would have to have actors and actions better defined.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think that is well said.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And we can decide if we want to come back and say what those should be, but I agree with Marc. We should probably move on.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, when Dixie comes back we can give it to her.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

... on her, that's brilliant.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Now I know why I never volunteer to do one of these things.

**Marc Overhage – Siemens Healthcare**

It's hard.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

It is really hard.

**Marc Overhage – Siemens Healthcare**

Dixie makes it look easy.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, she does.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

She'll just yell at us and whip us into shape.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

She's very good at it. I think she's practiced this. So now we're up to question 65, right?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

What types of criteria could be used for categorizing standards and implementation specifications for interoperability CTEs? We would prefer criteria that are objective and quantifiable and include some type of metric. I think that for this team we are already doing that, and why would we want to suggest anything beyond what we're already doing.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I'd go back to the criteria that are in the RFI that were called out: maturity, market adoption need, deployment complexity, and maturity of the underlying technology for a given standard. I would just almost cut and paste that language and say that's sufficient.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Aren't those the ones that we are using?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Exactly.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes.

**Ellen Lengermann – Office of the National Coordinator**

Those are the initial criteria, although through our efforts we've modified that list to include intellectual property ... .

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Right, intellectual property constraints, yes.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Good point.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, so, Matthew, if you can make a note to essentially describe the superset of the ones listed in the RFI plus the ones that we're actually working on in this Power Team when we were doing our day job. No, it's our evening job. This is our night job, I guess.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**Marc Overhage – Siemens Healthcare**

Quit whining.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Okay. Matthew, I'll be happy to help wordsmith that off line, if necessary. I think we got the spirit of that.

**Matthew Rahn – Office of the National Coordinator**

Yes, definitely. Thanks.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Okay, so now we move to the governance policy, is that what you guys would prefer, ONC, would you prefer? That's one, we're marked for that one, I'm not quite sure why. Question three, how urgent is the need for a nationwide governance approach for electronic health information exchange? Conversely, please indicate if you believe that it is untimely for a nationwide approach to be developed and why. The context, why is it important for ONC to exercise its statutory authority to establish a governance mechanism now?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I'd offer up on this. It makes sense in the context if you compare Meaningful Use 1 with the NPRM for Meaningful Use 2014 edition, there's an order of magnitude more interoperability requirements in the 2014 edition. So on face value it would make sense that you'd want to be attentive to making sure that the infrastructure between entities worked well. On the other hand, as we've had these conversations over time I think the answer to a whole bunch of questions has been, I have said this and I know that others have said it as well is, is there really a market failure here. Is there really a need to regulate on this particular item? Is this overreaching? Is there a reason why the markets won't develop this in their own way? I think at least one of the subtexts of comments across a number of working groups that I've been involved in is in some cases this has been clearly too much regulation, clearly a case where this is a regulation seeking a problem, as opposed to demonstrative market failure where regulation is required. So I would suggest that we ought to say something along the lines of the standards suggest that interoperability is important, but just because it's important does not mean that it needs to be large or heavy handed or impactful. And there are some ways in which the RFI, as written, I think even this working group has commented in our earliest discussions, that it's too much.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, so of course the statutory requirement for them to establish governance is there, like it or not, that's a congressional problem, but the question is what should the governance look like and how urgent is the need for it. I like what you're saying, in a sense we're saying it should be as light as possible to allow the market to work and maybe we can put something, I think consistent with what we've said before, with an emphasis on establishing core trustworthiness of the NwHIN rather than on detailed protocols maybe.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And market development and other kinds of activities are implied in a lot of this. That's a great way to put it.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

It has always struck me that the barrier to these things emerging spontaneously in response to markets is lack of trust and complexity of the contractual relationships necessary, and if the governance can address those issues, create context for emergence of trust frameworks, then the markets will take care of the demand for services. But we're drifting into personal philosophy here instead of –

**M**

Did I capture that all right, David?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

"The standards ... is important but just because it's important doesn't mean it needs to be large, heavy handed or impactful. Governance should be as light as possible to allow the market to work and should place an emphasis on," – "let the market work, and should place an emphasis on establishing a core trustworthiness ... of the NwHIN," and maybe just stop there with NwHIN instead of the "rather than." What do you think, Cris? You articulate this really well.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I like the way you said it, around what the issues are that we should be focused on, because that's where the problem is, the creation of a trust environment makes sense to me. But I think there's a number of other places in here, the deal with business practice, pricing, restrictions on scope, a whole bunch of other things that are not related to trust, they're related to creation of an exchange industry.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And I don't see any particular evidence that the federal government is needed to create an industry. I see the requirement why the federal government should have regulations that are congruent with the rest of meaningful use. But if we didn't have meaningful use, or if meaningful use had been in place for a while, it's not clear to me why the Feds would independent of that walk in and say, aha, we need to catalyze a whole new industry because we've got a problem here, and we're going to set rates and we're going to set scope of service and terms and conditions and contractual requirements of parties, because that's riddled through the rest of the RFI.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Okay. On this one, Matthew, maybe the beginning of that sentence, the standards suggest, how about the NPRM for Stage 2, with a great deal of emphasis on interoperability, just to capture that thought. I'm trying to address the thing about the urgency, why is it important for ONC to exercise its statutory authority to establish a governance mechanism now. So in the context of, as Cris pointed out, NPRM for Stage 2 really ratchets up the interoperability demands and we assume NPRM Stage 3 would do the same or even more. I'm not dictating, but yes. Interoperability is important, but just because it's important doesn't mean there needs to be large, heavy handed, or impactful regulation, how about that? It doesn't mean that there needs to be, and we can fine tune this, but –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I liked your observation instead of, and maybe to improve that last sentence, which is we see the core requirement of these regulations to establish core trustworthiness we question – Matt, do you want to try and give this an edit?

**Matthew Rahn – Office of the National Coordinator**

Yes, sorry. I like where you're going, Cris. Keep working on that one.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So if you could delete "the governance should be as light as possible," up through "establishing," keep the word "establishing."

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Right here?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, just delete that. I think what we were saying is we believe that the core requirement of this RFI is to establish core –

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

How about "core requirement for governance"?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I'm sorry?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

"Core requirement for governance."

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Thank you. "... is to establish core trustworthiness." And we probably don't want to reuse the word "core" twice. I like "core trustworthiness" here, maybe we replace the word "core" earlier with something else. On the NwHIN, maybe a sentence to follow this one, that says, I don't know how strongly we want to say it, is we're unclear or we don't see the need for additional regulation intended to develop an exchange industry such as the rules related to pricing, scope of service, legal restrictions on actions of parties, and so on in the RFI. That's not perfectly stated, but I keep hearing that comment in every workgroup I come to.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, how about, “We question the need for.”

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

There you go. Thank you.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

“We don’t see a need for,” or “We question the need for.” I’m just trying to make it a little bit more polite maybe.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

And wordsmithing, “But we believe that the core requirement for governance,” how about “We believe that the key requirement of governance” –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Let’s move forward. I have not read these carefully enough to know how much overlap with the next set of questions, but we may have to cycle back on some of these, ... . Question four –

**Marc Overhage – Siemens Healthcare**

Guys, I apologize. I have to run to do an EVA shift, so I will look for great wisdom in the draft that comes out.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Wow, don’t kill anybody.

**Marc Overhage – Siemens Healthcare**

I’ll try. Thanks, man.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Take care.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

See you, Marc.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Question four: Would a voluntary validation approach as described above sufficiently achieve this goal? If not, why not?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So the text is to say validation will be voluntary, in other words, the validation process established as part of governance would not be mandatory and would only apply insofar as an entity deciding that there would be value in seeking validation?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, so it’s voluntary to become an NVE, is that how you’re reading that, Cris?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I think so, although in other instances I think the intention is that you can’t act as an NVE without being validated. I’m having trouble parsing that.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Right, but the way you would become an NVE is to demonstrate compliance with the CTEs, is –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right, right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

..., so essentially we're saying participation in the NwHIN is voluntary.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Do we have any difficulty with that? This is a pretty small sample of opinions here, but I'm happy to provide them if no one else shows up.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well, what's the alternative to some mandatory requirement that should be an NVE? The question is, can you operate as an NVE or an NVE like entity in the U.S. for performing certain functions without being validated. I think that's the question, right?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I like to think of it as a brand question. If you want to display this brand, NwHIN, and seek the benefits of the implied trustworthiness, that means that you must volunteer to meet and be certified against these CTEs. So it's a do you want the brand or not? It doesn't mean that you couldn't exchange health data securely and safely and legally, you can obviously do that without being a member of the NwHIN, as happens today all the time. What's the difference of there is no financial incentive behind this like for the certification of EHR technology, so that's voluntary but it's voluntary with a big win if you go into it, there's a big incentive. In this case there is no incentive for participating NwHIN, there's no regulatory incentive, no law that says you get – right?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I may not be reading this right and I'm wondering if there's someone from ONC who can speak to it. Is the intent here that you – what you just said, David, is anyone can set up shop as an NVE and the validation process is just an underwriter laboratory seal of approval.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Anyone could exchange healthcare information, but they wouldn't be able to call themselves part of the NwHIN. They wouldn't be an NVE. They'd be functioning like an NVE, but they wouldn't be an NVE. Isn't that how you interpret it?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

That makes sense. I happily accept that. I have been reading this to date assuming that it would be the case that there would be some sort of connection between the governance rule and the CEHRT rule, that would say something like, for a CEHRT to show that they're engaged in directed exchange, they either need to act as an NVE themselves or they need to connect to an NVE for purposes of things like the 10% rule on exchange of clinical messages and patient communication or for purposes of lab exchange, what if the entity doesn't do it itself? I don't know. I've just been assuming that they would bind those two together. If they don't, it's better.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think that's a good point. Obviously the NPRM doesn't bind it together today, because there's no governing – the regulations as written today don't reference this, so they couldn't bind them together.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I can imagine in the future NPRM Stage 3 or maybe the final version of NPRM could say that the only way you get credit for meaningful use is if you use an NVE, in which case there's a strong incentive to become an NVE for those entities out there that want to survive commercially. But it would still be voluntary, as opposed to you can't exchange healthcare data unless you become an NVE.

**Matthew Rahn – Office of the National Coordinator**

This is Matt from ONC. I think the last sentence is key here, where it says, "That said, once a validation process is established, much like other government programs in which subsequent policy objectives could be leveraged, it would be possible for other public and private organizations to specify NVE recognition as a condition in awarding contract procurements, and/or in other situations where validation wouldn't be beneficial."

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Which page are you on, Matt?

**Matthew Rahn – Office of the National Coordinator**

Twenty-six.

**M**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think that's the key to question four.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

All right, so that's useful to know. I don't know why I didn't read this more closely in thinking about this. I had been assuming that the binding would be tighter. So I guess that begs the question, if this is entirely voluntary why the specificity and comprehensiveness of the regulations listed here? Typically when someone is doing something on a voluntary basis for purposes of prestige or competitive advantage the federal government is not required to create those kinds of recognitions, industry bodies do that themselves.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

But a voluntary criteria could be rigorous.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Of course. CCHIT established themselves without any explicit federal standard, right? There was no certification regulation.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Right.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And CCHIT came along as a way of accomplishing certain things, there's this HIE EHR interoperability thing that's been sponsored out of New York State, there's a variety of things like that, so I don't know. I'm just sitting here thinking why would we need the federal government to be so tremendously specific around things like prices you can charge each other and functions you can and cannot do as an NVE, and what are your privacy and security standards. If it's entirely voluntary and an entity can exchange health information without an NVE certificate, I don't know, I'm struggling with, on the one hand, a voluntary standard, on the other hand the level of rigor and comprehensiveness in this regulation. Maybe I'm the only person struggling with that. David, is it just you and me having opinions to say and staff is scratching their heads wondering what these knuckleheads are up to?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

You know what it practically speaking may come down to is whether federal partners require NVE status in order to do exchange. If 50% of healthcare spend says we can't do business with you unless you use an NVE, then it's a moot point about whether it's voluntary.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, exactly.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

But nonetheless, it could still be left as voluntary as opposed to say HIPAA, where covered entities have no choice; they must follow those rules, right? If you're a covered entity you don't have any choice. If you do electronic billing you are under HIPAA, period.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, I guess the question is, is this voluntary in a sense of you can be a non-profit entity only if you seek 501c3. In all other instances you must pay taxes. That's not really voluntary. What that's saying is that the federal government is not picking out entities and saying, we're going to force you to apply for some non-profit status. It's saying, if you want to be a non-profit and not be taxed you do these things. That's different.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

We're not even a policy subcommittee so I'm not sure why we're addressing this question, but what if we just said something that we agree with the voluntary nature of the RFI, however, it may be a moot point if market conditions essentially demand that entities that wish to participate in healthcare become NVEs. And we don't know that yet, but we would not suggest abandoning the voluntary nature just because of the uncertainty, would we?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I don't think so. I like that comment. I guess the corollary to that is calling it voluntary is a fiction if it becomes a requirement of federal procurement.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

(Inaudible.)

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes. And my concern would be that when we're looking at other regulations where there's an issue about it potentially being too intrusive, someone could say, oh, well, don't worry, it's just voluntary. Well, it's not if it's going to be a condition of participation in federal programs.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes. So how do we capture – this is not terribly useful advice but it is ... .

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I liked your comment that it may be moot if it's used in that fashion.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, particularly if federal payors require NVE certification. So something like, Matthew, “We agree with the voluntary approach, however, we’re concerned that this may be a moot point if,” do we just say “federal entities,” or we say “large entities”?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, I’d say federal.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

... entities, federal entities –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

... require –

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

... payors, because I think that really it’s the payors. It’s CMS and Medicaid. Federal entity payors require NVE certification for business partners, for trading partners, business partners – what’s the right word to use there?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Business partners is good enough, because it would include others that connect to NVEs. I’d also make the point that if –

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

How about we note that this may be a moot point? I’m not sure we’re concerned about it.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

... change it. We note that it may be moot.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I think I would suggest, see if you agree, to add a comment that says that, “If NVE validation becomes a de facto requirement, ONC should be mindful of the comprehensive nature of some of the proposed regulations in this RFI,” end of comment. They’re probably sufficient if they’ve voluntary. These are good ideas that ONC is suggesting that validating entities put in place, that’s fine, but if it becomes a de facto standard suddenly those good ideas and best practices may become really onerous.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Right. I like that. That captures our fears. I’m not sure that it’s going to give them much advice about what to do about it.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, that’s good.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Good.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Thank you.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Excellent, a fascinating discussion. Question, what's next, five, no eight. What's the feedback on the appropriateness of ONC's role in coordinating the governance mechanism and whether certain responsibilities might better be delegated to and/or fulfilled by the private sector?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So you're reading the RFI on 27 through 29?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Not yet, but I will.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes. I remember reading through this. This is where ONC says we're going to hold the rules and be the entity that issues regulations, and we're going to seek an accreditation body that then can accredit validation bodies and then oversee the validation bodies themselves and then observe, manage, and respond. And then it lists accreditation bodies and validation entities.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, and as I understand, the top level is the accreditation body.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

The top level would be endorsing and adopting CTEs, right? So if we're asking about whether this might be better delegated to and/or fulfilled by the private sector, I think we're asking the question who should endorse and adopt CTEs, should it be the private sector or ONC?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes. Well, and this is where I think some of the other discussions have noted that not all CTEs are created equal and that what we had euphemistically referred to as core CTEs that deal with security and privacy might be quite different than a CTE which is dealing with whether you support a direct protocol directly or not. I don't feel like the way the RFI was constructed makes a clear enough separation. Dixie said she considers all the CTEs to be high level, but there are questions in here about certificates and SNTP and REST, so I don't consider that to be high level at all. I never quite understood her point.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, so I think this is one of these things where, I'm struggling with this idea of voluntary again.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Well, so take the example of DirectTrust.org, or ..., for that matter, ONC could say if you want to become an NVE here are some high level criteria that you have to meet around, let's just pick security and privacy, and you could go and demonstrate that you meet those criteria, as could DirectTrust.org, at which point, at least for Direct Trust, ONC or ONC's delegated body. But let me just say ONC for the sake of argument, could say to DirectTrust.org we authorize you to validate NVEs that support the direct protocol, and you can charge them whatever fees you want for the certification process, you decide how to police them at whatever intervals you want, and if you're a private entity, go for it, but you're meeting these core CTEs around security and privacy, as opposed to ONC having to bless every HISP that wants to run direct.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, they're clearly pushing that down to an accreditation entity down to a validation entity for sure.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Right and do we think that is inappropriate or appropriate?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I guess, trying to think about this comprehensively, it sure seems to me as though if there was the notion of core CTEs that the industry could enhance and expand upon, it might very well make sense that in order to have consistent regulation from state to state and have smooth operating on a network and establishment of trust, that ONC, through the accreditation entity and validation entities, would establish those core CTEs. Maybe the question it begs for me is does that mean that ONC should be responsible for trying to anticipate and put in place every CTE, or would it –

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Could that be the basis of our response here, that we believe that some CTEs should apply to all NVEs and the degree to which they are related to that core trust framework, ONC is an appropriate body to be responsible for establishing those CTEs, but that other CTEs are application and use case specific, and those aren't the right words, but are more granular and could be delegated to private entities. In other words, what I keep hearing is that we're saying not all CTEs are created equal, some of them really do involve the trustworthiness of the entire framework, and some of them just have to do with efficiently running a business and being compliant with standards and so forth, which are better done by private entities like Direct Trust, or Surescripts, or –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Exactly. And Surescripts publishes this, so it's no big surprise, but a specific version of this script standard has, over time, been enhanced, NCPDP script standard has been enhanced in order to actually make the network run. There were some enhancements and modifications that have to be put in place. The certification criteria that an EHR uses to get its meaningful use certification is not the same as the certification required to operate on Surescripts, because there was a mismatch between the test cases, between Surescripts and what NIST put in place.

The same thing is true with respect to commercial clearinghouses, if you go to Emdeon or Payerpath or any of those kinds of organizations there's a variety of, I guess if you're being critical you'd call them proprietary extensions or modifications of the X12 standard, and I think if you were being more charitable you would say they are pragmatic modifications needed to make the network run at all. So I think we may want to say something along the lines of we anticipate that validating entities might create additional CTEs as needed for the efficient operation of NwHIN, and we might also say, I don't know what you think, David, but we might also say that we would suggest that it may be possible that ONC might choose not to establish CTEs in some instance, unrelated to core trust, in order to foster innovation. Would you agree with that?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, I think so, in principle certainly. I'm trying to think through the wording of it.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Matthew just took what I did verbatim, thank you, but it definitely could be wordsmithed.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, I was glad to see that. What I'm struggling with is this notion that a CTE, we need subcategories. So literally CTE stands for condition of trust at exchange and what we're, I think, recognizing is that there are, let me call them a condition for secure interoperability, or let's just call it a condition for interoperability that overlap with some of the things that get kicked around in the RFI as CTEs but really aren't CTEs because they really are interoperability profiles. Maybe the way to frame it using their language is that the CTEs that have to do with core trust should be the responsibility of ONC, but additional work by the private entities will be required to guarantee interoperability, and that that might not necessarily be ONC's responsibility.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So trust belongs at the ONC level and interoperability belongs with the validating bodies.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

That's fricking brilliant, David. I like that. I like that a lot.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Good.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

That's really nice.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Sure, the devil is in the details, but you've got to have a starting point, right?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, yes, yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Matthew, did you get some of that? Yes, so CTEs have to do with core trust, but additional work from private ... would be necessary to guarantee interoperability. Now, additional work, how about additional maybe certification standards, additional certification profiles ... processes, yes. CTE is condition for trusted exchange, how about, what did I say, a condition for –

**M**

Interoperability.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

CFO, no, that's –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

CFI.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, yes. CFI, condition for interoperability (CFI) in quotes, or something like that. In other words, what we're trying to capture, Matthew, is the distinction between trusted exchange, which is trust framework questions, and conditions for interoperability, which is really the validating body's responsibilities. And so I'm worried about our second sentence there. We suggest that it may be possible that ONC might choose not to establish CTEs in some instance unrelated to trust, and we've got that as a negative not an unrelated. How about, can we say that as a positive that ONC should focus on those CTEs necessary for establishment of the trust framework and should avoid CTEs that would inhibit innovation, something like that, Cris?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, I'm being quiet because you're being great.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

That might inhibit innovation.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I like that a lot.

**M**

What about the second part of the first sentence?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Oh, let's see. How about instead of saying on the lower level CTEs that are focused on interoperability –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, I was trying to get that back in there. You had a strong statement that ONC should focus on trust, industry should focus on interoperability, and I like that. It's a clear statement.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

We should wordsmith all of this. But that key thought was really important.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think these validation entities would be put into business by ONC but would perform their business as private entities.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

In a sense they get their license to operate from ONC, but they go about guaranteeing interoperability and implementing secure exchange as private entities, or public/private in a sense, I guess. Matthew, are you still typing or are you waiting?

**Matthew Rahn – Office of the National Coordinator**

I'm waiting.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Okay. In that first sentence up there, "ONC should focus on" – okay, wait a minute. What I wanted to say is that "ONC should focus on governance mechanisms to ensure trusted exchange and let the private sector, through the validating bodies, focus on interoperability." ... CTEs should apply to all NVEs in the degree that they're related to core framework could be ONC's, to core trust framework, that should be ONC's responsibility, but the CTEs that are focused on interoperability should be delegated to the validating bodies ... private entities.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Could we add: "in order to foster innovation," to the tag phrase?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, in order to foster innovation and efficiency, but we don't need –

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And efficiency, I like that a lot, actually. Thank you. This is really good. This is like a core piece of feedback to the whole thing.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Good, so we haven't completely wasted your afternoon, because you're on enough workgroups that are really focusing on these questions. This is the first time I've seen these questions in a workgroup.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

If you're referring to wasting ONC staff, I would agree; wasting my time, hardly. Although actually, David, just as a housekeeping item it would be ideal for me if I could stop at the top of the hour. I know we're scheduled to go until half past.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

And since that would leave no one on the call other than me, I think we'll just define that. I don't know, MacKenzie's probably not still listening, but MacKenzie, can we just agree to stop at the top of the hour?

**MacKenzie Robertson – Office of the National Coordinator**

Absolutely. We don't have to stay on the line if there's nothing more to discuss.

**M**

We'll need to set up another call, though.

**MacKenzie Robertson – Office of the National Coordinator**

Okay.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, well we've got an extended window now, so that shouldn't be quite as demanding.

**M**

How extended is it? Aren't they due next week, or is it the 20<sup>th</sup>?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

It's the 29<sup>th</sup>.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

The 29<sup>th</sup>.

**M**

Oh, okay.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

But there must be some internal comment, yes, MacKenzie, when are we supposed to finish our work, given the new –

**MacKenzie Robertson – Office of the National Coordinator**

The original dates that were set out are still what everyone's working off of. They're talking internally about maybe having some separate larger scale questions to send to the committees, but right now you should still be planning to submit your comments for the June 20<sup>th</sup> meeting.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yikes, no rest for the wicked.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So for the June 20<sup>th</sup> Standards Committee meeting?

**MacKenzie Robertson – Office of the National Coordinator**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

So we don't have to do it this week. We can wait until Dixie's back, in other words.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Is Dixie back next week?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I think she said she was just out a week.

**MacKenzie Robertson – Office of the National Coordinator**

Yes, I think it's this week that she's out.

**M**

MacKenzie, can we work to set one up for next week then?

**MacKenzie Robertson – Office of the National Coordinator**

Yes, I'm checking my list now to see if there is anything else already. It looks like we have a June 12<sup>th</sup> call.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Criminy, it feels like I have two of these a day, so there must be.

**M**

What time?

**MacKenzie Robertson – Office of the National Coordinator**

I have the call from 2:00 to 3:00. Is that on everyone else's calendar too?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, I've got it from 2:00 to 3:00 Eastern.

**MacKenzie Robertson – Office of the National Coordinator**

Okay. So we already have that call set up, it's an hour long, and then there's a, yes, June 28<sup>th</sup> is afterwards. Do we want to set up another one in addition to the June 12<sup>th</sup>, or do you want to try and extend the June 12<sup>th</sup>?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Why don't we try to –

**MacKenzie Robertson – Office of the National Coordinator**

I have to check with Dixie.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Why don't we try extending the June 12<sup>th</sup>, it works for me to extend it.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

I would rather knock it off in one two hour session.

**M**

Yes, if you see the question that I have up right now, my guess is, depending on how many people join the call, that there would be a lot of comments to that question.

**MacKenzie Robertson – Office of the National Coordinator**

Okay, so I'll just go ahead and have them extend the appointment from 2:00 to 3:00 to make it 2:00 to 4:00, does that work?

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

That works for me.

**MacKenzie Robertson – Office of the National Coordinator**

Okay.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, on that question 56, my catty response to that is that's what all these other questions have been discussing, is which CTEs are valuable. But anyway, we're not addressing that one yet.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

The Information Exchange Workgroup of the Policy Committee met earlier today and addressed that question and I think had the same answer, but I think in part because people didn't prep in advance. I'm going to be better prepped for this discussion, I think. I would probably want to go through and look at which CTEs look like they're irrelevant or unnecessary or whatever in the context of the conversation we just ended, and I'd make the argument that if it really is a voluntary standard and if we really are going to segregate ONC on trust and industry on interoperability here would be the CTEs to take out.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes. No, I like that. Let's move them into these categories based on this little framework that we've evolved here. That makes sense.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I'll do my best to read through them, if you will too, David, because I think on our last call there was a silence where we were all struggling with that because nobody had read ahead.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, I got it. I'll do it. And I think now maybe we have some time for public comments. I don't think we can address another question and get the comments. Is that okay, MacKenzie?

**MacKenzie Robertson – Office of the National Coordinator**

Sure. Operator, can you open the line for public comments?

## **Public Comment**

**Operator**

(Instructions given.) We have no comments at this time.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Cris, thank you for sticking it out.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Thanks for your leadership, David.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Good, I think we got a little bit accomplished.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes, and thanks to the ONC team. Thank you very much.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

Yes, you guys, wow, what service.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Indeed.

**M**

You're welcome, too, David.

**Ellen Lengermann – Office of the National Coordinator**

Thank you.

**David McCallie – Cerner Corporation – Vice President of Medical Informatics**

All right.

**MacKenzie Robertson – Office of the National Coordinator**

All right, thanks, everybody.

**M**

Thank you.