HIT Standards Committee Meeting
Final Transcript
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Participants

Janet Corrigan, President & CEO, The National Quality Forum
John Derr, Chief Technology Strategic Officer, Golden Living LLC
Anne Castro, Chief Design Architect, Blue Cross Blue Shield/South Carolina
Christopher Chute, Vice President Data & Health IT Standards, Mayo Clinic
Dixie Baker, CTO, Health & Life Sciences, Science Applications International Corp.
Jon Perlin, CMO & President of Clinical Services, HCA
David Blumenthal, National Coordinator, Office of the National Coordinator
John Halamka, Chief Information Officer, Harvard Medical School
Jodi Daniel, Director of Policy and Research, ONC
Jim Walker, Chief Health Information Officer, Geisinger Health Systems
Gina Perez, Executive Director, Delaware Health Information Network
Judy Murphy, Vice President of Applications, Aurora Healthcare
David McCallie, Vice President, Medical Informatics, Cerner Corp.
John Klimek, Senior Vice President, National Council for Prescription Drug Programs
Kevin Hutchinson, President & CEO, Prematics, Inc.
Elizabeth Johnson, Vice President Applied Clinical Informatics, Tenet Healthcare Corp
Stan Huff, Chief Medical Informatics Officer, Intermountain Healthcare
Douglas Fridsma, Arizona Biomedical Collaborative
Steven Finley, Senior Healthcare Policy Analyst, Consumers Union
Linda Dillman, VP, Benefits & Risk Management, Wal-Mart Stores
James Ferguson, Executive Director HIT Strategy & Policy, Kaiser Permanente
Marc Overhage, Regenstrief Institute & Indiana Health Information Exchange
Wes Rishel, Vice President, Gartner Corp.
Richard Stevens, The Boeing Corp.
Judy Sparrow, Programs and Coordination, ONC

Presentation

Judy Sparrow – ONC
Great thank you. Good morning everybody and welcome to the first meeting of the Health Information Technology Standards Committee, just to remind you that this is a committee that's operating under the Federal Advisory Committee Act, which means it is open to the public. We have members of the public here in the room at Switzer, in fact we have very many members of the public here in Switzer. We also have people listening on the telephone and on the web. At the conclusion of this meeting the public will be invited to make comments, those of you in the room will be invited to a microphone and on the phone if you care to dial in, a number will be given to you on the screen and you can make your comment via the phone. People on the web if you want to type in come comments we will make sure that they are made a part of the record. Also at the conclusion of the meeting the materials will be made public on the website, a transcript and summary of the meeting in about a weeks' time and a reminder to the members of the committee here in the room and on the telephone, if you would please identify yourself as you speak so the transcriber can duly note your comment. With that I think I will go

around the table here and have each committee member briefly introduce yourself and then we will go on the telephone and have those committee members. Janet, I'll begin with you.

Janet Corrigan – The National Quality Forum – President & CEO
I am Janet Corrigan, the President and CEO of The National Quality Forum.

John Derr – Golden Living – Chief Technology Strategic Officer
My name is John Derr, I am the Chief Technology Strategic Officer for Golden Living which is one of the largest long-term care providers in the country with hospice and NFs and the ALFs. Glad to be here.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
I am Anne Castro from Blue Cross Blue Shield of South Carolina, I'm the Chief Design Architect.

Chris Chute – Mayo Clinic – VC for Data Governments & Health IT Standards
Chris Chute at Mayo Clinic, I'm Vice Chair for Data Governments and Health Information Technology Standards and a Professor of Biomedical Informatics.

Dixie Baker – Science Applications International – CTO, Health & Life Sciences
I'm Dixie Baker and I'm the Chief Technology Officer for the Health and Life Sciences business at Science Applications International.

Jon Perlin – HCA – CMO & President of Clinical Services
Good morning, I'm Jon Perlin, I'm Chief Medical Officer and President of Clinical Services for HCA, I'm also in the faculty of Vanderbilt Biomedical Informatics and the privilege of being in a completely electronic world in a past life and US Department of Veterans Affairs.

David Blumenthal – National Coordinator – HIT
My name is David Blumenthal, I'm the National Coordinator for Health Information Technology and I will add my welcome to you in just a moment.

John Halamka – Harvard Medical School – Chief Information Officer
Good morning, I'm John Halamka and I'm the Chief Information Officer at Harvard Medical School, of Beth Israel Deaconess Medical Center and the Chair of HITSP.

Jodi Daniel – Health Information Technology – Director of Policy and Research
Hi I'm Jodi Daniel, I'm the Director of Policy and Research at the Office of National Coordinator for Health IT.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Jim Walker, I'm the Chief Health Information Officer at Geisinger Health Systems and Executive Director of the EHR Safety Institute.

Gina Perez – Delaware Health Information Network – Executive Director
Gina Perez, Delaware Health Information Network, I'm the Executive Director.

Judy Murphy – Aurora Healthcare – Nurse & VP of Applications
Judy Murphy, Nurse and Vice President of Applications at Aurora Healthcare. I'm Integrated Delivery Network in Milwaukee, Wisconsin.

David McCallie – Turner – VP for Medical Informatics

I'm David McCallie, I'm Vice President for Medical Informatics at Turner in Kansas City.

John Klimek – NCPDP – Senior VP, Industry Information Technology
Good morning, my name is John Klimek, I represent NCPDP, I'm the Senior Vice President of Industry Information Technology.

Kevin Hutchinson – Prematics & National E-Health Collaborative – CEO & VC
I'm Kevin Hutchinson, I'm the CEO of Prematics and the Vice Chair of the National E-Health Collaborative.

Elizabeth Johnson – Tenet Healthcare Corp. – VP Applied Clinical Informatics
Good morning, Liz Johnson, Vice President, Applied Clinical Informatics for the Tenet Healthcare Corporation and also a Nurse.

Stan Huff – Intermountain Healthcare & Univ of Utah, Dept of Biomedical Informatics
Hi, Stan Huff with Intermountain Healthcare in Salt Lake City and also with the University of Utah, Department of Biomedical Informatics.

Doug Fridsma – Arizona State University; Mayo Clinic – Associate Professor
I'm Doug Fridsma, I'm an Associate Professor in Biomedical Informatics at Arizona State University, I teach at the University of Arizona in the medical school and I see patients at Mayo Clinic.

Steve Finley - Consumers Union – Senior Healthcare Policy Analyst
Hi, good morning, I'm Steve Finley, I'm a Senior Healthcare Policy Analyst at Consumers Union which is the publisher of Consumer Reports Magazine.

Linda Dillman – Wal-Mart – Associate Benefits
Good morning, I am Linda Dillman, I work for Wal-Mart. I have responsibility for our Associate Benefits.

James Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I am Jamie Ferguson, I am the Executive Director of Health IT Strategy and Policy for Kaiser Permanente.

Judy Sparrow – ONC
Any members on the telephone please introduce yourself.

Marc Overhage – Regenstrief Institute & Indiana Health Information Exchange
Good morning, this is Marc Overhage. I am with the Regenstrief Institute and the Indiana Health Information exchange. Good morning everyone.

Judy Sparrow – HIT – Director of Programs and Coordination
Anyone else on the phone? Okay, I'll turn it over to Dr. Blumenthal.

David Blumenthal – National Coordinator – HIT
Thank you, Judy. I once had the opportunity to do advanced work for a senator and one of our premises was always to pick a room that was too small so that we could be sure that it looked like it was a very popular place to be. I appreciate all of you being here, members of the standards committee as well as members of the public. I appreciate your willingness to involve yourselves in this vortex of activity that has been created by the congress and the administration in the form of the stimulus bill and the high-tech provisions of the stimulus bill and the enormous opportunities and challenges that are associated with that legislation and with the goals that it has set out for the United States in the area of health

informatics and Health Information Technology. This committee is a committee that is going to really help us get the technology, or at least the standards, right for this activity, but I do want to draw you back to the larger picture; the larger picture which explains why we are here. You can't pick up the newspapers now without seeing the discussions that are going on about the future of our healthcare system. There are really two issues that are under discussion.

One is the issue of providing American's access to high quality healthcare and efficient healthcare and the other is the discussion about how to organize our healthcare system so it can deliver on that promise of coverage. In the organization of that healthcare system there is no part of the picture, no part of the change that we need to make that is more important than how we manage information, and no part of the management of information that is more important that the technologies that we use to provide that management capability. That management capability is going to make healthcare better and more efficient, or if it fails to do that we will have great disappointment and indeed great jeopardy for our healthcare system going forward. So we all in inviting you here, are hoping that you can help us deliver on those very high ambitions. We are also moving because those statutory deadlines, especially the requirement that we meet the promise of the legislation that American physicians and hospitals and other providers of care that wish to be meaningful users of Health Information Technology by 2011, that we make it possible for those well-intended and hopeful providers of care to in fact take advantage of the incentives that the congress has made available to them. So planning back from that 2011 deadline creates very, very strict imperatives that have moved us to bring you here with less preparatory time than we might have liked, less ability to very carefully plan your agenda than we might have liked, but we hope you will stick with us while we move forward with parallel processing in multiple venues. We are working on multiple programs and multiple policy directives at the same time while we are convened here. We convened our Health IT Policy Committee earlier in the week, we convened you today in fact because there was a statutory deadline that we do so, but we also want to get you here and talking to one another and learning who is on the committee and beginning to develop the ability to work together.

I am extremely grateful to the two Johns who surround me here, Jon Perlin and John Halamka for taking on the burden of being Chair and Co-Chair respectively of this group. I have known them both for a very long time, they are both terrific contributors to Health Information Technology and to leadership in medicine generally and they are going to more than earn the very modest non-monetary compensation that we are able to provide them.

We are trying to keep ourselves in this discussion constantly focused on health and efficiency, and both health for individuals and health for populations. Meaningful use which is in some ways the driving concept and a very I think useful concept, is something that we think of always in terms of health; the health of individuals and the health of populations. And I urge you when you're thinking, when you're talking about standards and technologies, the cost we have in mind, how will our decisions lead to and/or facilitate meaningful use and how will meaningful use lead to the improvement of a chronic illness or an acute illness or the management of a long-term care problem for whatever the agenda is, but try constantly to keep in mind the application to people in hospitals, doctor's offices, long-term care facilities wherever the situation might be, and I think with that grounding, we will have a much higher probability of producing results that are both usable and leave space for innovation in the healthcare system as we go forward. So again let me thank you for being here and I am very happy to have now surrender the podium to the two John's.

Jon Perlin – HCA – CMO & President of Clinical Services

Thank you very much, David, for your inspiring start to this set of work and want to think all of us are enthusiastic about the aspirations that I think you laid out Dr. Blumenthal's editorial in the *New England Journal of Medicine*. I think it is so articulate on the point that, its not about the technology, it's about the technology as a vehicle to improving the health and care that can be a provided. The words of accessibility, efficiency, effectiveness, safety, resonate with all and I think there is a demand to be able to, to meet those aspirations wherever I think my co-chair and I feel very much the urgency not just because of the national need, but I think this committee and let me thank each and every one of you for making what will be a substantial commitment. Because the urgency is actually prescribed not only by that national need but its actually locked down in statute and as you've read through at the high tech act that it really compels us to good bit of work in a very rapid amount of time. In many ways, as Dr. Blumenthal said this will be the most complex meeting because it is one where we set the agenda, the pieces are just beginning to come into play but then there are sometimes that I think we can reasonably anticipate. You know as we were chatting beforehand, John Halamka, who I feel so very honored to work with, and has been such an incredible contributor, our hope as a committee is to emulate Wayne Gretzky and skate, if you will, to where the puck will be, and I hope in that regards that it provides enough clarity despite the ambiguity but you know leaves open the work that needs to occur afterwards. Again framed around the ability to move the individuals who are the actors, to the ability to use technologies, as to deliver safe and more effective, more efficient and ultimately more compassionate healthcare.

If I might just take the prerogative of a few seconds to elaborate on my history as I came into the Department of Veterans Affairs in the late 90's and at that point only 6 out of 10 patient encounters were supported by electronic information. When colon cancer was diagnosed it was often late stage and it was horribly unfortunate. Over a period of time as a electronic health records supported a transformation, the care really did become safer and more effective, more efficient, even more accessible and in fact more affordable. Prevention was able to be delivered. I know that journey that lead to a visibility to serve those who serve their countries more effectively really inspires me to want to help contribute to the broader journey. It's far more complex, its not you know a single integrated health system, it's much, much messier and there are lots of moving parts. And this committee as you recognize brings together many of those moving parts but also the statute requires insight and input from other individuals, so that those parts go together as well as possible to help reach that end aspiration of savor more effective, more efficient, more compassionate healthcare, higher value, higher performance healthcare and we so much appreciate the lead of you, Dr. Blumenthal, and the office of National Coordinator and the President. Let me turn to my esteemed co-Chair, Dr. John Halamka.

John Halamka – Harvard Medical School – Chief Information Officer

Great, well wonderful to work with you all, I have worked in several incarnations with several of you before and I think we have an amazing opportunity right now, we have the alignment policy, we have regulation, we have incentives. In the past couple of years we have done some very good things with working on technology, we have looked at use cases, we created standards, we done certifications but implementation hasn't been completely aligned, there haven't been the resources to do what the regulatory requirements, the imperatives, the urgency and now I see an alignment that has never occurred before in history that will allow us to get the implementation, so I think our measure of success as you said should be meaningful use, real use of these technologies, real exchange of data by 2011 and beyond. I think in this country there has been a lot of structural barriers to actually exchanging data, you know sure, there have been issues of gaps with standards, there have been technology limitations but there has not been a will in the country to say we are going to break down silos between payers and providers and patients and actually exchange data and we'll do it for the public good, we'll do it to improve the care the population. And so starting today as we as a committee gather and will begin to work on as you've described it, "skating to where the puck of meaningful use will be", it should be our

goal to now take this great foundation that David has laid for us and figure out those standards that are going to get us to true implementation of data exchange by 2011.

Now we shouldn't just say the status quo is fine, oh we are already doing some prescriptions, we already doing some labs, we should say let's stretch ourselves. You know I believe that when we declare the standards, we shouldn't set the bar so high, that we will leave all of rural America behind and we will leave the small doctor's office without the ability to reach the bar, but nor should we accept the status quo, so to me with these stakeholders around us, 25 great minds who represent so many different parts of healthcare, let's work together. We'll get reports on where we are with regard to the standards and the data interoperability today and then to think about how to stretch ourselves a little bit so we can get to that meaningful use you're looking for. Now I wish today we had a crisp description of what meaningful use is, but we have from the policy committee and we will hear from Jodi about this, you know a direction of where they're heading and so Jonathan and I have met this morning and we've chatted with David and we'll postulate to you a few ideas which I will call contingency planning about what meaningful use might be. Now, David, of course isn't ready to declare today in this meeting that our guess is correct but I think you know as we begin this discussion and gather all of your input you'll probably find it rational to start thinking about medications and labs and quality, care coordination, seems like a starting point and so I'm sure and we'll hear from Jodi and Jonathan further that our next couple of months will be a lot of work together, meetings in person that are public, workgroups together in formation in the background, working virtually wherever we can, I mean I do love getting together in small rooms like this, it builds togetherness and esprit de corps but I think we will also hear from Jodi and the Office of the National Coordinator that there is an urgency of getting this work done because we want public comment, we want to meet the statutory requirements, so all I can tell you, I hope you didn't have any vacation plans this summer because we'll be on the phone together but we will be making a great difference and just to end with, it's been an incredible time and so lets grab that brass ring and let's make a difference and change healthcare in America.

David Blumenthal – National Coordinator – HIT
Thank you and you know if we could give you a definition of meaningful use we would, we're working on it, but there's also going to be regulatory process relating to meaningful use which means that even our recommendation, your suggestions will have to go through a complicated process of public discussion, so it is going to be important that all of us think about options and do what we can in a period of uncertainty to prepare for what's likely to come down the pipes.

John Halamka – Harvard Medical School – Chief Information Officer
So let me introduce Jodi Daniel and ask her to take us through some of the process that describes statutorily and then we will come back for further discussion both about the process of our activity as will as initial thoughts about how we translate that urgency that is both statutory and frankly the opportunity of the moment and translate that into our activity.

Jodi Daniel – HIT – Director of Policy and Research
Thank you, John. I have the pleasure of trying at least explain some of the wisdom that we read from the statute from congress to help folks think about what scope of this committee is, how it relates to some of the other activities that we required to undertake, how it relates to the policy committee and all of that. For the members of the committee there is a PowerPoint, when I talked to the policy committee and I was talking to the statutory language, it seemed in that conversation that might be helpful to actually put it in writing so folks can refer back to it when we have our conversation later so, I have provided that to you.

So just to start, the statutes sets forth the committee's purpose to recommend to the National Coordinator standards, implementations, classifications and certification criteria for electronic exchange and use of health information. So that is sort of the frame of what this committee is charged with doing. This clearly is going to relate to the incentive payments for meaningful use as you've heard, of certified electronic health records technology, so the recommendations that come out of this committee will have a significant impact on the work that we are doing with respect to the certification process, with respect to incentive payments and the like. I do want to stress though that this is a Federal Advisory Committee which means that the recommendations that come out of this committee are in fact recommendations to the Department, and then we still have to go through our process to make a determination as whether or not to accept those recommendations but of course with the brain trust around this table and on the phone, I expect that the recommendations that come out will definitely provide us a lot of input and be something that we are going to rely heavily upon.

So with respect to the scope of the work, the statute also sets forth that any recommendations from this committee should be consistent with Federal Health IT strategic plan and with the policy recommendations from the Health IT policy committee. So as was stated already the Policy Committee met on Monday, the thinking there was the Policy Committee set the priorities, the policy priorities and then the standards committee can best look to what are some of the standards implementations, specifications and certification criteria to meet the priorities that the policy committee provides to us. So we see these committee working hand in hand, the Office of the National Coordinator is supporting both of them and we expect that we will sort of be the glue between those two to help make sure that there is an understanding of what each group is doing so that we have collaborative efforts rather than over lapping efforts and the work of both committees are both consistent and moving in the same directions so can that be supportive of our work. As far the Health IT strategic plan that that should also requires that we update our strategic plan so that's something that we need to do internally there is a strategic plan now that is in existence and that we could look to in the mean time but that is a process that would be ongoing in our office as well.

The statute also, in addition to identifying standards, implementations, specifications and certification criteria that tie to certified electronic health record technology and meaningful use, congress set forth 8 specific areas that the committee should begin with in identifying and making those recommendations, so on the next page this is where I thought it would be helpful to have this written out so you can look back on this later on. It goes through the eight categories that the committee as suppose to start with according to the statue. Just to briefly walk through these, the first is on privacy and security, the technology is to protect the privacy of information and to secure electronic health record as well as technologies for segmenting sensitive information. The second is to focus on nationwide Health Information Technology infrastructure that allows for electronic use and accurate exchange information to the standards in that area. Utilization of certified electronic health record for each person in the United States by 2014. The fourth is technologies that allow for accounting of disclosures made by a covered entity, this is tied to HIPAA privacy rule requirements that individuals be able to request an accounting of certain closures that are made with respect to there protected health information, so the committee is supposed to look at standards in that regard. The use of certified electronic health records to improve quality of healthcare, technologies that allow individually identifiable health information to be rendered unusable, unreadable or indecipherable to unauthorized individuals, and this is related to the requirements that congress put out regarding breech notification requirements. We recently put out guidance that we are in the process of seeking comment on in this area, so this is something that we have already taken a step toward but we required update that guidance every year so we would be looking for this committee to provide us some guidance in that area. Seventh is the use of electronic systems to insure comprehensive collection of patient demographic data including race, ethnicity, primarily language and gender information. And the last one is technologies that address the needs of

children and other vulnerable population. So those are the congressionally stated starting points. Clearly there will be other areas that we need to look at, some of those, I think there is a lot of room for discussion about what we need to talk about with respect to those eight areas but I wanted to make sure folks are aware of those.

So the responsibilities of this committee, obviously I have already mentioned to make recommendations to the National Coordinator of standard implementation, specification and certification criteria, also to recognize harmonized or updated standards from an entity or entities for the purpose of harmonizing or updating the standards and implementation specifications and we can talk about what that might mean. And then to provide for testing for such standards by the National Institutes of Standards and Technology. So this group can be making recommendations for NIST to do some testing of standards and most likely before a formal recommendation comes to us as to a standard that we would want to include in our set of standards that the Secretary recognizes. So some of the process and how some of this ties into our other work.

The first thing is I think it was David who mentioned our statutory obligation with respect to this committee. Congress has specifically requested that the Health IT Standards Committee develop a schedule for the assessment of policy recommendations developed by the Policy Committee. So there is this statutory tie between these two committees as we have recommendations from the Policy Committee this committee will be considering those with respect to the standards piece and today we will be talking about a general schedule for how this committee plans to operate with respect to recommendations that we receive from the Policy Committee and we will plan to publish that after this meeting presuming that we are able to accomplish that and meet the statutory deadline. We are required to update that schedule annually so that we will be regularly adding to the schedule and then making sure that we have a publication annually to give people a sense of our time line and the issues were taking on and to conduct open and public meetings and a process for public comment on schedule and committee recommendations.

I want to talk a little bit about the standard adoption process because it directly ties into your timing and how you can best be helpful to provide meaningful input into our processes. The statute sets forth two standards adoption processes; an expedited one for right now for the initial set of standards and then the regular process. So under the expedited process, HHS is required to publish an interim final rule with our initial set of standards implementation, specifications and certification criteria by December 31st of this year which if anybody, for folks who are aware of regulatory process, that's really fast. Fortunately it is an interim final rule so we will be meeting that deadline, that is our expectation and so that is why Jon and John suggested that the early phase of this discussion might have to be expedited so that there can be an opportunity for some input into that process. We will have to regularly update the standards implementation, specification and certification criteria as the standards develop, as the products development, so this is sort of an ongoing process that HHS will be engaged in and will be looking for your input as we update those standards as well.

The other point on this expedited process is that congress specifically articulated that we can rely on prior HHS processes for identifying and recognizing standards implementation, specifications and certification criteria. So to the extent that, most folks know, for some folks of the public we had the prior process with the American Health Information Community, getting recommendation from HITSP, the Secretary recognizing and accepting those standards. We can look to the standards and criteria that have already gone through those processes in putting forth the initial set of standard, so we will be taking advantage of that statutory language as well.

The normal process, this is just in the next eight months, is that the Health IT Standards Committee will make recommendations to the National Coordinator, so we'll assume that, you know, once we have gotten through the standards that were in the prior process and we are looking at new standards that may not have gone the prior process, we would be relying on this committee to provide us input into those, and then there is a statutory process that is triggered that provides for an opportunity for comments on the recommendations that come out of this committee and for the National Coordinator then to consider those recommendations to make recommendations to the Secretary and for the Secretary to make a decision on whether or not to adopt those standards, so there is a very detailed bureaucratic process that is put in place, built-in to make sure that we both get public comment, as well as to make sure that we have taken the time in HHS to access the recommendations that come out of this committee and to think about the implication of adopting those standards.

So if you turn to the last page, there is just a very small flow chart, I just wanted to sort of put this in a graphic so folks can see how this all fits together. So first starting, the policy committee will provide recommendations from a National Coordinator, if we accept those recommendations we would bring those to the Standards Committee, to let you know what came out of the Policy Committee and bring that link together. The standards committee will be making recommendations about standards, certification criteria and implementation specification and organizations that we should be looking to for standards development harmonization and certification criteria development and whether or not we need to actually ask for some organizations to take a look at some areas where we need new standards where there might be some gaps.

As I had mentioned this committee can also recommend testing of particular standards, NIST would be the entity that can do that testing and this committee may want to consider making suggestions for NIST to do testing before making final recommendation to the National Coordinator's office, once they go to National Coordinator's office that process kicks in of National Coordinator Review Recommendations to the Secretary and then finally HHS's adoption of the recommendation. So that is some of the processes, the role of committee, how we see this relating to our work, to the work on the Policy Committee, and some of this will be developed over time as we start working through the different committees and see how things develop.

Jon Perlin – HCA – CMO & President of Clinical Services
Well thanks Jodi, it's pretty clear this is going to be a highly caffeinated group to meet this, the aspirations but as John Halamka said the golden ring really is the improvement in health and care and so I know everyone comes to this table highly motivated. That was a terrific overview and I'm sure that generates a number of questions because there is a lot of moving parts. There is the charge within the statute, there is a process aspect of the relationship with the Policy Committee and the National Coordinator and there is that which is prescribed for our attention, those eight domain that were identified as well as some of those things that I think we can anticipate, that have been telegraphed but not overly prescribed in terms of effort. So I'd like to initiate some conversation about how we approach our work, it looks if we might divide it into two pieces and the first let's be very practical and turn to Jodi for any answers to any, or clarifications of any process aspects that we have just heard or anything that you want to understand better from the statute. And Janet Corrigan has a wonderful convention that has been started here and this way John and David and I will make sure to see cards that are up so if we adopt that convention as your process that is terrific, so Janet Corrigan.

Janet Corrigan – The National Quality Forum – President & CEO
Thanks, that was a great overview. The one question I had was I understand from your comments, I think, how sort of the relationships would work when it pertains to the standards. It's less clear to me the certification criteria process because I think, although I realize the definition of meaningful use

hasn't been settled on yet, it seems to me quite likely that certification criteria will not exist for the definition that is likely to emerge or at least certain aspects of it. Where does CCHIT fit in and what would be the process for either getting certification criteria developed that don't currently exist and then what is the process for testing them within the timeframe that we are talking about who would do that?

David Blumenthal – National Coordinator – HIT
Well I think that is probably a question I should take

Jodi Daniel – HIT – Director of Policy and Research
Thank you.

David Blumenthal – National Coordinator – HIT
Actually I am going turn back to Jodi. [Laughing] The answer is that we are working hard on reviewing certification process, we are looking at alternatives and we are going to try to bring back our recommendations and our thoughts to this committee and to others as soon as we can do that. We are also doing the same with meaningful use and when I referred to parallel processing that was one of the things I had in mind, that you may, this committee may have to work thinking about contingencies for a certain amount of time until the work of the Office of the National Coordinator and of the administration becomes better defined. A week ago, I guess it was a week ago, Monday, I guess it was, it seems like a week ago when the HIT Policy Committee met, I could still say that I was just beginning my third week, I'm just concluding my third week here, I don't know whether four weeks means I am a veteran but I would like to hide behind that recent arrival still for having a few of these issue are still up in the air.

John Halamka – Harvard Medical School – Chief Information Officer
Maybe this is a question to extend now for Jodi, we are the statute and the operating process that we had reviewed not only authorizes but requires input from variety of entities, so to be determined the specifics of that process but that's part of what's implied.

Jodi Daniel – HIT – Director of Policy and Research
Sure yeah, this committee can hear from whoever you all feel will be helpful to hear from and thinking through this, you could hear, we could have CCHIT come in [INAUDIBLE]. As David mentioned the Policy Committee is planning to look at the certification process, we can also have somebody from the Policy Committee or David as the Chair of the Policy Committee come and update this group on some of the thinking that is coming out of that group, to the extent that it might inform your thinking on the certification criteria. So yes all of that is possible.

David Blumenthal – National Coordinator – HIT
I should have mentioned that the Policy Committee has formed a three working groups, one of which is dealing with certification and adoption and another which is dealing with meaningful use and the third is discussing exchange and privacy and security are, it was decided at that meeting, should be rather having its own subgroup should be an pervasive consideration across all those groups. So we are going to be getting input from the Policy Committee on those topics, we have internal interagency groups working on both those topics, that is certification and meaningful use, and so and we are trying very hard to get to our own, our own thinking resolved, so we can bring that to you for your reaction.

John Halamka – Harvard Medical School – Chief Information Officer
Just go round some at table. Steven?

Steve Finley - Consumers Union – Senior Healthcare Policy Analyst
Yeah this is a corollary question to Janet about HITSP. John Halamka and his team of incredible volunteers have done amazing work over the last couple of years and I am wondering how you can explain to us today perhaps John and David how that is going to fit in to what we do, probably different levels of understanding around the table about HITSP's work and how it is going to fit in here.

John Halamka – Harvard Medical School – Chief Information Officer
Start with that and then I can provide specifics to what's HITSP doing to [INAUDIBLE].

David Blumenthal – National Coordinator – HIT
Why don't you talk about what HITSP is that everyone has a common ground then I can react.

John Halamka – Harvard Medical School – Chief Information Officer
Sure. So the Healthcare Information Technology Standards Panel is a group of 600 volunteer organizations and these are from payers and providers, employers, the public, the government, attorney's etc., and they've come together over the last 3½ years to harmonize standards. Now that means we look at all the possibilities, if a use case requires the exchange of a certain kind of data, how might we do it. If there are competing mechanisms to do it, we try to figure out what the best one or two might be.

It has produced a serious of deliverables called Interoperability Specifications. Now this was what we were asked to do by the previous administration. Here is a use case, produce a document to describe the standards to meet the needs of that use case. We now recognize that the stimulus bill and meaningful use requires a bit of a different construct. So what we've done is that we have gone through all of the previously recognized and accepted standards and we are reformatting them, rather than to be use case based or interoperability specification based to be much more data element and functionally based. So for example; if it might be that e-prescribing is important for meaningful use rather than burying the various vocabulary transmission standards and the way we describe a prescription in a interoperability specification, it is an electronically published index that says oh, I need to name a medicine, ah, there is one way to do that, and that is RxNorm, you know there is one way to describe a SIG, one way to get a refill transaction done. So an implementer, a vendor or a hospital could go to this electronically published resource and much more easily, at a data element or functional basis pull out the standards they need.

Now again I will turn to David and to Jodi here but my understanding is when we look at this chart, that all of that work be accepted and recognized work now reformatted to be more aligned with a need of meaningful use is coming from a harmonization organization and therefore it is an input to this committee and presumably should this committee identify that there are gaps or extensions that entity could also receive a marching order, go fix this and it would report back to this committee.

David Blumenthal – National Coordinator – HIT
Now let me just say that I think everyone myself included is enormously appreciative of the incredible amount of work that HITSP has done over the years and the leadership that John has shown for that organization and we are adopting a view that again end-oriented, goal-oriented, not technology or process-oriented not, without in any way depreciating the value of technology or the value of the expertise around this table and technology, we just want to focus on uses and what doctors and hospitals have to get done in there daily work and John's concept is taking what has been done, reconfiguring it so that its related to use, is I think a very, very useful and functional way of thinking about this so we don't have time to remake the world, we have to get a lot of work done and HITSP I think will continue to be a very important resource for our work.

Kevin Hutchinson – Prematics & National E-Health Collaborative – CEO & VC
So I'm the guy that's always the joking party usually stating the obvious but I'm going since we are in the introductory mode of the committee, I'm going to state a few obvious, you know, points. One, I'm thrilled that this committee has expanded beyond just standards and focusing on the implementation of those standards as well as the certification because I think in past processes, simply focusing just on those standards and not focusing on the other two elements left the gaps on what to do with that. I think that's going to be very helpful.

One of the things that I would and this is the obvious in coming, one of the things I would encourage us to do is to look at the, where they may not be mass quantity there are great examples of where these standards have been implemented in the private sector. So when I look at you know prior to doing Prematics, I was the founding CEO of SureScripts and we started an organization to try to drive e-prescribing and working with NCPDP as a standard, created and accepted a standard before it became you know part of the Medicare Modernization Act which was very helpful in established as the standard. But then creating implementation criteria and implementation processes, certification process there are many examples, whether it be Delaware or Indianapolis and other places where there are HIEs that have gone to some of these processes as well and I know that that's part of our, even our core mission is to outreach to some of those private sectors that have experiences in the implementation of these standards. Even where there is identification issues, it's one thing but I think where we're going to get a lot of experience from the private sector is the attempt to actually try to implement and certify technologies to the use of those standards.

Jon Perlin – HCA – CMO & President of Clinical Services
Obviously, we were thinking, anticipating the different bodies of work and when going through the statute toward the synthesis that Jodi provided, obviously as you say, it's not just the specifications but the actual implementation and when one begins to consider the concept of meaningful use it really is a very practical level and what it means at different identities and different individuals and I think the statute was very foresightful and effective in anticipating the need to seek input and indeed that's part of our charge to bring that. And the representation around this table also I think is a very broad ability to get public input as well, so there is a process that will really ground us not only in standards but our effectively articulately tested and adoptable but also incorporate experience of actual practice.

David Blumenthal – National Coordinator – HIT
Yeah, I just have one comment, I don't want to dominate

Male Speaker
Hello?

David Blumenthal – National Coordinator – HIT
Hello?

Wes Rishel – Gartner – VP
Hi, this is Wes Rishel, I have been having difficulty being heard, I just want you know that my virtual card is up.

David Blumenthal – National Coordinator – HIT
So Wes, David Blumenthal, let me just make one short comment and then I am going to retire into the background here. I didn't say in my opening comments but Kevin's comments reminded me of it and that is on the general topic of innovation. One of the great fears that we hear and that I see in my e-

mail a lot and over the phone and in comments that I receive has to do with whether the federal government, through the process has been created which we are now a part, will have the effect of by developing complicated standards and complicated implementation recommendations and a very high bar for certification whether we will suppress innovation in the market place with respect to software and end up freezing in place certain what will become antiquated technologies. This is something that my office has constantly on its radar screen and continually asks itself are we doing anything that will result in a slowing of innovation in a field that is inherently innovative and were the best is certainly yet to come, so with respect to Kevin's points about an implementation and certification, it is great to have those on our radar screen but it also is a very delicate responsibility where we really need to keep asking ourselves are we asking too much, are we asking the right things, have we left enough space, while still protecting the public, now I am going to stop there.

Jon Perlin – HCA – CMO & President of Clinical Services
Well thank you it's very helpful. Let's go to Wes Rishel who's on the phone, Wes.

Wes Rishel – Gartner – VP
Thank you. I have written about the process that was going on before, I would like the opportunity to share that note with the committee members but fundamentally my concern is that the waterfall approach of producing a standard and then rolling it out to the industry without a fast feedback process or dealing with issues that come up can't work and hasn't happen because there is a specific change off of responsibility from producing the specification and have it being recognized and then have it be it implemented. So I hope that we will have a chance to within the balance of the legislation to attempt to create a better feedback loop. On the separate comment of innovation versus standardization, I think that it is important that we recognize that that is always a balancing act that we might have better cell phones now if the weren't locked into certain standards for how they communicate, but very likely we would have a hard time talking to our neighbor on the cell phone. So that the important thing is to establish processes where standards are focused on what is needed, but either assure the bean counters that they're getting their value or to assure the actually assure interchange or correct functionality and that we establish a process for evolution of standards without throwing out investments that have already been made.

John Halamka – Harvard Medical School – Chief Information Officer
Wes, this is John Halamka and just as a comment when I read the legislation and speaking with David in the sense of where the National Coordinator is going, I believe there will be a very different set of processes that really ensure accountability that is end to end. Because in the past an interoperability specification was the result of a use case, so that would mean use case writers here's a great use case, we're done. And then standards would be placed around it and HITSP would say we've met the letter of the use case, we're done and then we would hand it off to the implementation community and there would be certification criteria but these as you describe as a waterfall, went from organization to organization to organization rather than to say the goal is the improvement of care, did we actually make a different end to end and can we be held accountable for the entire continuum from goal to execution and that's, I think, based on the stimulus and based on David's approach what we'll see. So this committee as Kevin has highlighted will be charged with much more than just the narrow standards production but actually making sure they are certified implemented tested and then David will take responsibility for getting meaningful use out of them, we hope.

Wes Rishel – Gartner – VP
Thanks John, that is precisely what I am concerned about and I would only add to that. As the standards committee we need to assure that as we move between those phases we have a way to go back and identify very specific issues that come up and fix them much faster than the full regulatory loop.

David Blumenthal – National Coordinator – HIT
Appreciate your counsel on that but I really am taken by John framing earlier at the alignment. The opportunity now, it's not just creating a product for market, but that there is a market so that pull of, that the incentives have offered really I think will be something that fosters both innovation and the ability to implement. There are two cards up and one is a virtual card because it keeps falling over and Dixie Baker and then Anne Castro. Dixie?

Dixie Baker – Science Applications International – CTO, Health & Life Sciences
Yes. Now you know the klutz of the group, I couldn't get mind to stand up. In this assessment schedule and also in the text that Jodi researched. There seems to be an obvious dependency here that I would like a little bit more information about and that's the dependency. We are to review the recommendations of the policy committee and we don't have a date for when the policy committee recommendations are due, so is there, do you know that date?

Jodi Daniel – HIT – Director of Policy and Research
No. There wasn't a date set on when recommendations or the schedule for when recommendations will be coming out of the policy committee. We, David had talked to the policy committee that he hopes to have folks work very quickly and some of the subcommittees or the workgroups that were formed to bring back recommendations. You know we're sort of operating, you know we're trying to get everything moving at once, it's a little bit of a challenge and what I would say is that, in some areas, you know in order for you all to move forward I think you can make some assumptions and as we have some recommendations coming out of the policy committee you can work from those. You are not necessarily prohibited from talking about something other than what came out of the recommendation from the policy committee. Those should be something that should help set your priorities, but if there is something else that, from the collective wisdom of this group you think needs to be something that you take on, you can raise other issues other than what comes out of the Policy Committee, you need to consider the things that come out of the policy committee but you can also take on other issues as well. With respect to the actual, if you're talking about how does we come up with a schedule, well we don't have. I think you can say, from such time as you receive a recommendation this is how you will forward and then as we get some more clarity we can always revise that. So this I think is going to be somewhat of a work in progress.

John Halamka – Harvard Medical School – Chief Information Officer
Because I would think that there are two threads of work, the one which, the policy committee delivers a specific policy request to us and then we would develop a schedule that was concrete but you have deadlines of 12/31/2009 so like anything we have to back ourselves up from that deadline and we realize if we wait for the policy committee we will never meet your deadline so therefore we need contingency work that is our best guess, if they got three workgroups, meaningful use, what might that be and what standard do you think we'll need. Exchange, gee what kind of things should we provide from a standards perspective to foster exchange and we have that at the contingency ready for when the policy folks report to us.

David Blumenthal – National Coordinator – HIT
We'll take Anne's question but Jon has just tee'd up the body of work that we'll do before the break and the first part is to anticipate some of the areas, respond to some of the things that are in statute and have come forward from Paula's committee and to plan for ourselves a list of concrete tasks and following the break we'll talk a little bit about the schedule and the schedule may be less type of specific activities and more conceptual in terms of the time course that we would allow ourselves and how we conduct the process of the work. So with that as sort of setting the transition let's take the last question

on this phase and then let's have some discussion on clarity around setting up some tasks for ourselves. Anne?

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
Hi, thank you. My question is related to the reality of everything else that is going on during this same time period, including the 50/10 changes that are going to flow down into everybody we're going to flow down into and the ICD-10 which many people haven't even started yet, thinking about but you know even in, even though in the 12 and 13 timeframes the work is going to be done and I know there is incentives for providers to start using what we come out with but they're going to be jumping into an immediate change and the vendor situation is going to be, I'm going to supply a product that meets the certification criteria but I'm going to have to turn around and make major changes to it to meet the letter of the transactions that are being impacted by the 50/10 and the ICD-10 coding and then I just want to put on the table that I think it would be a good idea if we created a road map of all of the activities that are going on in the time period up through the major goal of 2014, you know having that PHR out there for everybody because that is really all the same continuum of system feeds, I said PHR but it was the 2014 goal. So it's really a bigger picture and it's a bigger impact and what we're going to be doing has to have a practical application in actual work to get this stuff transitioned and I know from my perspective I'm already doing the planning, I've already got a schedule laid out, I know when things have to happen, I know when I'm going to tell my providers they have to make things happen because I'm an insurer, Blue Cross & Blue Shield of South Carolina. So I'm a key cog in the wheel of setting up when people are in a position to even take on that task, even if you give them $40,000 to do it, there are still bigger issues out there that we have to make sure we just take into account. So that road map idea is something that helps us in our planning and I think it will, you know back at my shop but I think it'll help us in our planning here.

John Halamka – Harvard Medical School – Chief Information Officer
One comment Anne and that is, you've talked about quality and efficiency. Well, one aspect of efficiency is administrative simplification so administratively we want to assure that every payer and provider are actually doing the business of medicine as well as they can so in addition to labs and pharmacy and clinical care and quality, how do we move to the next generation of administrative standards? So now we have a statutory requirement to get to ICD-10 by 2013 so we're going to go from 16,000 diagnostic codes to 170,000 diagnostic codes, 12,000 codes alone just for angioplasty. We at the same time have to now transmit that new set of diagnostic information and to date we use something called the X12 4010 standard. It is not capable of supporting ICD-10 so we all have to move to 5010, the next generation in the standards which means that Anne is going to be retooling all of her internal systems.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
And all of my providers are going to be retooling there because they're not going to want additional administrative effort to have a continuum of information going from healthcare, seeing the patient to being able to bill for it, being able to maintain a health record that helps them with their next illness, all of that is a continuum of the same information.

John Halamka – Harvard Medical School – Chief Information Officer
And the joy of being a CIO is that you are being told, here's a new mandate, here's a new compliance requirement and by the way, all five are happening simultaneously and there is a finite number of people who can execute the change as well as a finite amount of change any organization can tolerate, so this notion of, how do we stage this? How do we phase this? What is reasonable to assume we can achieve by 2011 and then 2013 for all of these compliance requirements is important.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
Yeah you don't want a failure because you didn't take into account that a provider might be more concerned about how much they are paid than the clinical quality of care and that could happen because one standard is based on how I'm paid and another standard is based on how I take care of a patient.

John Halamka – Harvard Medical School – Chief Information Officer
Very true.

Jodi Daniel – HIT – Director of Policy and Research
I think you make a really great point and I think this is the kind of thing that we hope will come out of this committee to make sure that to the extent there are other things that are going on that might affect implementation, that we make sure that we're taking those into account in how we stage standards adoption and certification adoption. So I think that is incredibly helpful to bring that up.

Rick Stevens – The Boeing Company
This is Rick Stevens and I apologize for calling in late, I'm not sure how to put my hand up so I just want to put my card up and whenever it is appropriate get called on.

David Blumenthal – National Coordinator – HIT
I was just going to say that the other thing that your input can help us with us is feeding this information back to our colleagues on Capitol Hill who create these mandates but often aren't aware of the full complexity that people in the real world are dealing with.

Jon Perlin – HCA – CMO & President of Clinical Services
The other things I've heard and am exquisitely sensitive to as well is the need for having a calendar that shows what is coming down the pipe because this reality of adopting certain activity, if there is also the ability to plan for it with greater clarity.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
If we anticipate it we can build into the process helps or sensitivities which will get us a success.

David Blumenthal – National Coordinator – HIT
Well thank. So Rick, we recognize your virtual card. Rick Stevens.

Rick Stevens – The Boeing Co.
Thanks very much and I apologize for calling in late and not being there in person. I look forward to being at the next meeting in person. What I'm struggling with and I think many of us are struggling as I listen to the conversation is that it is not clear, we have a common understanding of what are measures of success are and it is not clear that we all understand the process that is going to get us to a system that meets the measures of success. As an employer when I look at this Health IT system I think about it in terms of some fundamental values that we're trying to achieve and that is to provide transparency of healthcare cost and quality from a patient's perspective, from a doctors'/nurses' perspective, from a hospital's perspective and from the payers perspective. Again I apologize I didn't here the remarks earlier, but is there a definition of the process that we're going to go through that is going to lead to us achieving what the expectations for this committee are and how do I get a hold of that process?

Jon Perlin – HCA – CMO & President of Clinical Services
Well, Rick, let me just acknowledge your comments because I think they really capture a consensus of aspiration. The aspiration is not the technology; the aspiration as Dr. Blumenthal so eloquently laid out

in his comments today as well as in the New England Journal Editorial, it is about improving healthcare, health of individuals and the population, improving the efficiency and improving the accessibility and so all those things imply a derivative set of measures. The process Jodi Daniel walked through with some degree and to be sure you are absolutely in the majority that we are working through a process to determine how we approach, but just to synthesize and I think this is a complex enough aspect, that there are a number of inputs that we received; the statute itself, the working process here, some initial insights from the policy committee and we have been using the analogy of us getting to where the puck is going to be, it is pretty clear that there is a need for greater articulation of the concept of a meaningful use and without foreclosing what that is, our next conversation really amongst this group would be to lay out some potential contingencies should it be formally asked of us to define and be able to answer yes this can be support with reasonable standards. So this is going to be a bit of a working process. The best picture I think is the single last slide in the most recent PowerPoint that shows that relationship as Jodi Daniel explained that there are some statutory deadlines that really compel us to early action, even perhaps in anticipation of request recognizing that the formal flow is from the policy committee through the National Coordinator.

Rick Stevens – The Boeing Co.
Okay So one of the things I will do is when I'm in DC next week, I will see if I can line up some time with Jodi to understand where Jodi is taking us and then provide my input in large scale systems integration that might be helpful.

Jodi Daniel – HIT – Director of Policy and Research
Sure thing!

Jon Perlin – HCA – CMO & President of Clinical Services
And your point at the very outset, that this is the unifying premise, is that it is about high-value, high-performance healthcare but to get there we have got some intermediate steps. So with that, I really think that is a good transition to helping to anticipate that proverbial puck and offer the opportunity for individuals to put some contenders on or anything you might like to offer in terms of guidance from the Policy Committee.

David Blumenthal – National Coordinator – HIT
No, I await on your guidance!

John Halamka – Harvard Medical School – Chief Information Officer
Certainly in the legislation itself there is a statement about electronic prescribing, there is a statement about quality; you might imagine that we have the statute to look to in those regards.

Jon Perlin – HCA – CMO & President of Clinical Services
And as well in there the electronic and interchange of information to support continuity of healthcare. Okay, we have got Elizabeth Johnson.

Liz Johnson – Tenet Healthcare Corp – VP Applied Clinical Informatics & Nurse
I think it is obvious that when the policy folks met on Monday that they established three groups. It would seem relatively obvious that we might want to line ourselves similarly to that and anticipate the standards that will be required by each group, just as a thought in terms of quickly aligning, because I think we are going to have to go with what we clearly understand and what we don't clearly understand and start moving forward or we will not be able to meet the deadlines that we have had imposed. Just as a thought for consideration.

Dixie Baker – Science Applications International – CTO, Health & Life Sciences
But they also, as many of you know I have a particular interest in privacy and security and they did not form a group around that, and that is an area where I have to tell you, I do not know exactly what is going to come out of the pot with the committee in that area. So it is a difficult area to anticipate and has huge implications regarding technology standards.

Liz Johnson – Tenet Healthcare Corp – VP Applied Clinical Informatics & Nurse
Yeah, you're right, in reading what was transposed from the meetings, it is quite interesting graphics that came off as what was being written as we went, I think the idea that become clear to me is that everyone felt as you did, which is it is critical that throughout all of our discussions that must be paramount on our minds. So whether or not we chose a different route and say we need to focus uniquely on that, but also charge every working group to say this is part of the admission you must keep this in mind, is a choice we have.

David Blumenthal – National Coordinator – HIT
I think the statute gives us some clarity in terms of the eight domains. There are two that directly speak to the issues of privacy and security. They are actually a very specific circumstance, one is accounting for disclosure and the other relates to ensure that individually, it is titled 'Security for Breach Notification' but specifically that individually identifiable health information be rendered unusable, unreadable or indecipherable to unauthorized individuals and so it mentions the issue of authorization. I'm sorry, for the very first one, you're absolutely right it is privacy and security and sensitive information and segmentation of specific information as well. So I think one of the realities of our scope is that it is potentially very broad. I think given the statutory guidance that there is a pretty large body of work and your point is well taken from both of you that that is one bolus.

In terms of anticipating the manner of use I have heard a couple of contenders out there in the discussion thus far, e-prescribing was one. John you tee'd up, you might want to tee up with what we have heard thus far?

John Halamka – Harvard Medical School – Chief Information Officer
Right so not only from the statute but just from chatting with many, many people and many stakeholders groups you hear e-prescribing, you hear laboratory electronic transmission ordering of laboratory, you hear clinical summary exchange for care coordination and quality measurements; HITEP for example with Janet and NQF have been very focused on the quality side of things. So those four elements seem to be very commonly discussed. We certainly want to hear the input of others if you're hearing in your world that meaningful use might be something beyond an initial say straw men of those four.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
What were those four again?

John Halamka – Harvard Medical School – Chief Information Officer
The e-prescribing, laboratory, clinical summary and quality.

Jon Perlin – HCA – CMO & President of Clinical Services
There is a card.

David Blumenthal – National Coordinator – HIT
There is cards and indeed and, the symmetry with the statute once again, and David McCallie. Thank you.

David McCallie – Cerner – VP for Medical Informatics
Yes, thank you. This is David McCallie. Just to put something John on your list to consider, someone asked me a few weeks ago what was the most important and most commonly used standard in healthcare data exchange. It was a trick question and the answer is of course fax. Right! So I wonder if secure message provider to provider or provider to payer etc., secure messaging in response to specific HIPAA TPNO-type transactions that don't require additional interpretations of privacy and sharing because we already have well-established, if that should be on our list of things to do what do we replace the fax with that allows us to treat the data electronically?

John Halamka – Harvard Medical School – Chief Information Officer
And just to clarify that, by secure messaging what you mean is rather than using AOL, Yahoo! and Gmail then how might we use appropriate security technologies whether that is a secure email system or a web-based exchange mechanism to communicate text messages from stakeholder to stakeholder.

David McCallie – Cerner – VP for Medical Informatics
Right.

John Halamka – Harvard Medical School – Chief Information Officer
That could be provider to provider, provider to payer, provider to patient; secure messaging in general.

David McCallie – Cerner – VP for Medical Informatics
And it would immediately get us into the scope of authentication and authorization; who are we talking to, how do we know who we trust? Because I think until we have confidence that there are robust ways to know that we can trust that the person on the other end is who they say they are, we are at risk of not getting very far very fast. We will have systems that we are afraid to plug-in if you would because we don't trust that it will be talking to the right people. So secure messaging exactly in the way you described it would be something that would flush out some of those issues early on, I would say probably web-based tools would be the likely leading contender and it would engage the patient, it would allow for exchange of summary documents to the consumer via secure message if they requested it for example as a stepping stone towards more repository or aggregation-based sharing which I think is going to take a little longer to work out. This is just a suggestion.

John Halamka – Harvard Medical School – Chief Information Officer
And that actually was one of the use cases that HITSP worked on in 2008 so there is a body of work around that.

David Blumenthal – National Coordinator – HIT
Stanley Huff?

Stan Huff – Intermountain Healthcare
The proposed list I think seems appropriate. As I think about it from what we typically need clinically to take care of patients, there are a couple of things that I would add. I think it is not only e-prescribing but in fact what we would like to also know about is medication ordering so that you have the in-patient component of what is happening with medications. The other thing that seems sort of essential to understand quality as well as to understand a lot of the relationships is some capability in the system to know what are the health issues/problems/diagnoses for the patient so we can make some correlation between what the patients conditions are and this lab data and the pharmacy data and other things. The third area that I would mention would be, and actually I think is pretty doable are all of the text reports that physicians use. So the prime things are radiology reports and then the written pathology

reports, anatomic pathology reports and then other things like discharge summaries, operative notes; all of which really are covered by if you can pass one kind of text document you can pass them all if you have the terminology created and I think has great benefit. Just from the clinical perspective lab data yeah, medication data both the orders and prescriptions, text documents and then that health issues/problem list/diagnosis so that you know the underlying condition of the patient in order to correlate the rest of that data I think are some fundamental focuses that we could attack.

John Halamka – Harvard Medical School – Chief Information Officer
When I had proposed the term clinical summary admittedly I did not define that but to me as a clinician, I am an emergency physician, I think of a clinical summary as a well-formed problem list; a medication list, an allergy list and then some reporting documents that could be an op-note, a discharge summary, it could be the last laboratory, there could be some text that comes out of a departmental system; that sort of thing. I think one of the interesting aspects of our committee work together is defining even what a clinical summary might contain because it may subsume many of the things you have described.

Jon Perlin – HCA – CMO & President of Clinical Services
Thanks John. I was hoping you would articulate that more broadly because I think that really is at a very practical level what is needed to be able to provide responsible care. Kevin Hutchinson?

Kevin Hutchinson – Prematics & National E-Health Collaborative – CEO & VC
Continuing on the theme of where the puck is going it reminds me of six years ago when we were first starting to figure out how to do e-prescribing and the comments made about, it was all fax and so there was no 'e' in examination-prescribing it was you write it in a tool and then it faxes it to the pharmacy; there is no medication history, there is no refill requests, there is no other information. So at that time it was about going to where the puck was going was to get it to be a fully automated process between pharmacy, health plan, BBM[ph], physician. Now if we look at e-prescribing and we think about where the puck is going, the thinking of e-prescribing needs to expand beyond the old definition now of e-prescribing which is new and renewal and transactions that go back and forth between the entities and more focused on medication management. Now if you look at medication management and really around electronic prescribing it now entails things like adherence compliance abuse, applicable use of medications and if we look to where the puck needs to go we need to go beyond simply just the exchange of information now between entities and really have standards for are we managing medication use for patient care, and do we have the standards for the management of that medication use beyond simply the exchange of prescription information between entities.

Jon Perlin – HCA – CMO & President of Clinical Services
I think that is well said.

David Blumenthal – National Coordinator – HIT
Thank you. Chris Chute. We will start, and we'll go around from there.

Chris Chute – Mayo Clinic – VC for Data Governments & Health IT Standards
Thank you. Obviously I agree with much of the added perspective that has been raised. I would add another layer in that we have to be careful we don't get into the moral equivalent of an electronic fax in that we can exchange data, do it electronically but still not have it's meaning affectively conveyed. And if we're going to consider the notion of standards I want to raise the dreaded semantics word because it is important to have what is ultimately exchanged understandable not only by humans but ultimately by systems that can manage and interoperate with that information. There is the 'I' word again. So that we have to be careful and I presume incremental. Actually it would probably be a great victory to have electronic interchange of humanly readable data nationally, no argument there, but we have to be

careful not to stop at that process or architect it in such a way that going past that to having machine-interpretable data is going to be difficult.

John Halamka – Harvard Medical School – Chief Information Officer
That was very well said. Many reports have said, if all we could do was take the human-readable text and go from provider to provider so humans could understand what was done, that would be a great victory but wouldn't it also be wonderful to have physician support so that when you got a well-formed problem list that was coded in SNOMED CT and you had a medication list, oh and labs were coded and you could actually then say hey doc, this problem, this med, this lab; badness is about to happen intervene now and so the controlled vocabularies, but it has to be a journey as Chris has said. We know it is not a greenfield out there, doctors aren't thinking in SNOMED CT when they write problem lists yet but they are starting to, and so we will I hope, in this work together and say yes free text for certain circumstances, better than nothing! And here is the journey to getting that vocabulary semantic interoperability that you have talked about.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
I have bad news.

Wes Rishel – Gartner – VP
This is Wes, my card is up again.

Male Speaker
Okay Wes, there are a few cards on the table. We will come back. Let's begin with Anne Castro, Janet Corrigan and James Ferguson.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
One of the things that has happened with standards is that they do a wonderful job of saying what you have to have on them but it doesn't tell you how you have to say it when you get the print out. My example is what is the eligibility of a patient, and it looks seventy-five different ways depending on which insurer you are working with even though we all comply with the standards, and we are all HIPPA compliant, it is a joke because the information is conveyed seventy-five different ways and vendors to not synthesize the data into a single way. I think that goes to when you go into a physician office and you are asked to fill out the little form, that is because they want the information like in their face and right away. It is what is your problem today and what medicine are you on, so I am backing up the fact that we need some sort of a practical fast pass to medical data and we do not create something that is so complex and deep and wide that every time you have a patient come in your office with your fifteen minutes that you can't even get to the medical record to get any other useful information, do you see what I am saying? So the argument is for a fast pass but also in a format that is standard across everybody.

John Halamka – Harvard Medical School – Chief Information Officer
Very, very briefly. So we start with the 270-271 for benefits eligibility that CAQH core provided a vocabulary for actually saying, so you are eligible but let's stand a standard representation? So yeah, so it's a journey.

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
Yeah and that is a place we don't usually go when we talk about standards so that is what I am lobbying for. Quickly, in addition you have the list of four and we talked about text information, go ahead and address images. You want to see the CAT scan, you want to see the lab results, you want to see the x-

ray and there is technically no reason why that cannot be a part of an electronic medical record that is shared so we need to go that extra step.

David Blumenthal – National Coordinator – HIT
Terrific. We're hearing a lot of very practical guidance. I think there is a consensus in making sure about computable information but also a practical approach to get to that as well. So the point is well made. Let's see, Janet Corrigan I think is next.

Janet Corrigan – The National Quality Forum – President & CEO
I am going to encourage us to not only be practical but to also make sure that we take just a little bit of time to step outside the very traditional medical system box, because we are trying to take the healthcare system through sort of a paradigm shift from one that was very frankly physician-clinician focused to a system that is patient-centered. I think that does call for thinking a little bit about standards and information capture in four areas. I think we do want to pay special attention to how information on health behaviors is captured within the system. Second, whether or not there should be standards that have to do with treatment, patient and family caregiver management of their own condition and understanding their treatment plan. The third area I think to be more patient-centered in the delivery system is to begin to think more systemically about how we capture and use information on patient outcomes beyond mortality which we do capture now but not very well or very timely frankly in many cases. This is an enormous sector and it is probably the only one that truly doesn't routinely capture information on its impact on patient outcomes, so moving beyond mortality and intermediate outcomes like readmissions to real health functioning information. Last but not least, I think we need to think a little bit about patient engagement and decision making. It is an extraordinarily opportunity to remove waste from the system when we look at the projections of what Medicare alone would save in terms of its expenditures on procedures if we engaged patients more readily in making decisions about treatment options. So I know that takes us a little out of the practical realm and I truly appreciate that we do want to be practical and focused on the near-term but within a broader concept of where we want to be down the road as well, we may have some opportunities to do a little bit in this area.

Jon Perlin – HCA – CMO & President of Clinical Services
Well thank you. I think those points are so important because it defines the extension of outcomes beyond the rather digital alive, not alive, to things that are much more meaningful or equally meaningful to patients in terms of the functional outcomes. But you have also recognized the patient as the center of this process and ultimately downstream the ability to make sure that information is transportable with all members of the process with the patient at the center. James Ferguson next and then we will summarize and take a break and come back. I'm sorry? We'll go to James and then to Wes. Okay thank you for the…

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I just wanted to take a minute to reflect back on some of the introductory comments that were made about what level we set the bar at and the fact that is it possible certainly to set the bar for standards at such a high level that a majority of physicians can't implement it in a reasonable timeframe. It is also possible to set the bar, and my great fear is actually that we set the bar so low and make it so easy to cross over that we don't achieve the quality and delivery system improvements that really are some of the goals of the HITECH act. So in listening to the large number of different areas of standards that have been discussed in this section of the meeting, it seems to me that we are at that point of potential danger or having a concern about setting the bar so high if we really full specify all the standards that have just been described, that may be very difficult for many physicians and other providers to implement in a short time frame. At the same time I think it is important to make some progress in all of those areas so it may be that we are at a point where we can start to think about which are the

particular areas where we want to set the bar relatively higher and then set the bar somewhat relatively lower in some of the other areas that have just been discussed perhaps as parts of a longitudinal summary record for exchanges as John was describing where leaving some things just in text but having a greater level of semantic interoperability to use Chris' term for certain areas. My recommendation for those particular areas just from this particular discussion go back to many of the same things Dr. Halamka mentioned of medications, labs also. Medications in part because of the potential for adverse drug events and the serious impact that your prescribing can have and then labs in part because over half of all ordered procedures are labs so that is obviously very important, but I might disagree with John on the prevalence and the potential for using SNOMED in the near-term and I would add standardized problems and problem list to the short list of things where we might want to set the bar relatively higher. Then in some of the other areas have just structured messaging that would set the bar somewhat lower for easier implementation in the short term.

John Halamka – Harvard Medical School – Chief Information Officer
Jamie and I never disagree! So I bet his real deaconess is actually with Betsy Humphries help going live with SNOMED problem was this week, so it is ready for primetime but not everyone is quite ready to implement.

Jon Perlin – HCA – CMO & President of Clinical Services
Okay well I appreciate. Wes you have the entire group reminding me that you are on the phone with your virtual card up.

Wes Rishel – Gartner – VP
Well I appreciate their help. Jamie raises an interesting point by implication which is we need to know where the puck will be when? In particular the limitations that David set out very early in this meeting relative to timing leads us to need to set the bar low in order that a significant number of physicians can qualify for payment in 2011 which starts October 2010, and yet we would hate to leave the bar there so I think we need from the Policy Committee, from the relationship of ONC with the legislature, whatever the right approach is, we need an understanding of how the bar will raise over time; first of all that it can raise over time and how it raise over time so that we can triage the levels that we would set the bar at. I would ask us to consider the following facts of life if you will, and in our approach and in our assessment of the timing with which we can achieve measures of meaningful use. The first is the asynchronous life cycle of IT systems. Whatever we put in place has to be accessible as a retrofit to systems that are already in use as well as accessible to newly designed systems and I would suggest that we not assume that what is going on at John Halamka's Hospital is an easy retrofit for systems that are already in place.

There is also the asynchronous knowledge and behavior cycle of physicians which is to say that they learn and they learn how to use systems and they learn the importance of what they are doing over a period of time and if we get too far ahead of them in our standards, then we risk a continuation of what I can only describe now as Health IT rage that we see going on among physicians. I think we in particular as we look at the benefits to society and to the healthcare system of capturing and exchanging structured data, we consider the direct impact on the physician in terms of the time spent documenting a case or creating that structured data and we would be [INAUDIBLE] in terms of deciding how to get the best structured data without totally disenchanting the physicians. I think that we all agree that there is a need to raise the bar, that there is a need to evolve our standards over time and I want us to consider very carefully what I call frozen interface syndrome which is the reason that if you look at HL7 lab levels, 2.1-2.6 now the industry has frozen somewhere about 2.21 on the average which is the reason that the OSI replacement for TCP/IP got so far as to be mandated by most of the governments of the western world and never happened, that our approach to standards initially must allow them to be upgraded

asynchronously; that is not all systems have to move to a new standard at the same time. Thank you for the time.

Jon Perlin – HCA – CMO & President of Clinical Services
Thanks Wes. Let's hear from James Walker and then we're going to summarize, take a break, this room is very warm. So James, the last word?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Thanks. Jim. I want to sort of amplify what Wes said. Healthcare is incredibly complex and healthcare IT is incredibly complex and when it is implemented all kinds of things can go wrong, and so it isn't just a matter of physician comfort and performance or productivity, it is a matter of patient safety to make sure that we get this right. One of our clear experiences is that when you implement HIT you have to do it in a phased way that people can cope with so that they aren't so overwhelmed cognitively with trying to use the new system that they forget all the basic things. We have had twenty-year nurses asking our shadow trainers nursing questions while they were learning how to use the EHR because the EHR had knocked out of their brains things that they had known for twenty years. When we went live with our in-patient system we did 50, 000 person hours of testing of that system before we went live and then we found 4,192 issues in the first four weeks. We resolved 2,900 of them and have the others on an issues list that we continue to work. This is unbelievably difficult to do in a way that genuinely improves patient care and we really need to stay serious about that particularly when we are thinking small practices and small hospitals. We work with hospitals that have three IT people, total. One gets pregnant, one gets sick and it is just crisis mode all the time for them.

Jon Perlin – HCA – CMO & President of Clinical Services
Well thank you for that. So we have heard all ends of the spectrum from optimism, I don't know if we have heard any irrational exuberance but we have heard optimism and we hear caution as well. We have also heard a framing that talks about what the ultimate goals are and yeah there is a chance that bad things can happen, there is also I think an even better chance that good things can happen if we move in the manner that the collective guidance offers. Let me take a crack at summarizing and we will come back and translate this into a schedule. We know that we have a bar out there providing information for interim final rule development by 12-31-09. We have to anticipate a fair amount of activity with relationship to meaningful use. We have had a good discussion as to what are practical needs and what are contenders. We have heard guidance that the bar has to be high enough to make real progress, but it has to be paced enough for reasonable adoption and the word phased approach and other comments around that, in terms of getting to where the puck will be, assume that bar is raised over time, and the challenges of life cycles of associated equipment, asynchronous replacement and knowledge and behavior. Just on the flip side, it is a real note that we have a cohort of young health professionals who are frankly very frustrated by the absence of this technology as that formal testimony to the Harris pollsters that some physicians under 35 are looking not to associate with entities without these sorts of resources.

What do we hear as potential contenders? We heard medications, e-prescribing. We also heard, if we think about where the puck is going to be, medication use, in-patient record, understanding more about compliance. There are other pieces that might be further downstream but we should foreclose from consideration over the longer pole and lab being such a broad component of the orders that are generated. We talked around clinical summary in a variety of ways, we talked about the need for a coherent synthesis of why is the patient here, what concerns they have, how do I assure to quote John Halamka that this lab, this medication, this problem in isolation and not known to me don't leave to catastrophe, how is that synthesized?

We heard about some pieces of that, that we have a subcomponent that is oriented around structured message transmission to transmit parts of that as well as the broader picture, is there some sort of clinical summary that can be transmitted. We had a little bit of discussion on quality and would remind that that is both the premise and statute into proving the ultimate value of healthcare delivered. We started the discussion with privacy and security and indeed that is three of the eight domains that were identified for work on. We also heard, I appreciate the reminder that the patient is at the center of this, that engaging the patient and being able to incorporate information around health behaviors, patient and family caregiver decision making, patient outcomes including functionality, engagement and decision making are critical elements. We have a list of things that may meet the test of some lower bar aspects, we have some aspirational aspects that may be some thing that escalate over time and we have the broader context of making sure that information is accessed under the right circumstances and is appropriately protected and engages the patient.

So I think that does justice to framing what will be I think an equally challenging discussion as how we tackle actually the work of coming to some guidance for the National Coordinator. Let me before I give David the final word on whether we seem to be on the right process, let me turn to John Halamka for any other thoughts.

John Halamka – Harvard Medical School – Chief Information Officer
Well I think you did a very good job at summarizing the discussion. I am a lumper and so I were to describe everything that was said, there was a set of administrative transactions which you described, there was a set of clinical care transactions around lab, e-prescribing and clinical summary and we also heard images, there was a set of security constructs which are secure messaging, transport and there are of course things like authentication, authorization, audit disclosure; the whole security side of this and then there is quality. An aspect of quality that is not only a quality measurement but its outcomes, functional status, treatment plans etc. So not to presuppose how we might organize to do the work, but seemingly those broad themes encompass all these transactions.

David Blumenthal – National Coordinator – HIT
Terrific summaries. Obviously no lack of work to do. I wanted to just for clarification point out that the law does anticipate a changing definition of meaningful use over time, and that you could define standards for any aspect of contemplated meaningful use even if you contemplated it being implemented in 2020. You are not bound to think just about 2011 so you can give the Office of National Coordinator or Secretary a set of standards that are independent of time if you have time to get them done and do the things that you think we need to do in 2011. So in that sense you have a good deal of freedom to think about what your work schedule can be. There is this requirement though that among those potentially infinite number of standards that you might develop, there has to be a group that you think is appropriate to 2011.

Jon Perlin – HCA – CMO & President of Clinical Services
Thank you. No we have been using this hockey analogy all morning and it reminds me, we're sort of corrupting a famous hockey coach guidance to the team, the team he said each day you skate better and better and today you skated like tomorrow! So I appreciate the hard work in the first part and David will make you skate like tomorrow in the next session. So let's break for fifteen minutes and come back at 11 o'clock sharp and we will resume with the schedule for these activities.

[BREAK]

Jon Perlin – HCA – CMO & President of Clinical Services

Okay let's go ahead and thank everybody for reconvening. The room is mercifully cooler. The average brain is 55 watts obviously, obviously there has been lots of wattage in this room and I appreciate the hard work. So we have a couple of tasks remaining. Importantly we want to hear public comments. I think this last session was fairly critical because we had taken our role of anticipating what's coming down the pipe I think very responsibly and responsively because some of this again is in statute; the concepts of the prescribing information exchange and quality are indeed specified. In the eight domains we know that three of those domains address the issues of privacy and security. So with your agreement, we could put our heads together a little bit and say well you could do it standard area by standard area but we may kind of bump into a lack of coordination. It is pretty clear there is an intense amount of work and it is also clear that we will need expertise to identify potential gaps. What if we addressed the areas of e-prescribing, lab exchange, clinical summary, quality, privacy and security in three working groups amongst us? One will be clinical, one will be quality and the third privacy and security. Within the clinical, for example the lab, the e-prescribing and the clinical summaries and other information transmission could be encompassed in that. Does that sound like a reasonable approach? Clinical, quality and third privacy and security.

Male Speaker
What would quality do?

Jon Perlin – HCA – CMO & President of Clinical Services
I didn't hear an enthusiastic response from Dixie!

Dixie Baker – Science Applications International – CTO, Health & Life Sciences
I was trying to hold up my card!

Jon Perlin – HCA – CMO & President of Clinical Services
Oh okay. You have a comment?

Dixie Baker – Science Applications International – CTO, Health & Life Sciences
Yeah the standards that we prescribe, especially in the terminology area in clinical are those that will be used to measure quality most likely, so it seems like there orthogonal. Chris agreed with me too!

Jon Perlin – HCA – CMO & President of Clinical Services
Okay. I think that is a fair point. There seems to be a sequentially to being able to use the clinical data to provide, really the end goal is to be able to improve healthcare. So that aspect has been recognized to a sense.

John Halamka – Harvard Medical School – Chief Information Officer
Jon, maybe you could actually summarize the work that HITEP is doing and why, actually you guys are correct that the atomic constructs that feed quality are in clinical, but there are also frameworks for quality measurements that are being devised.

Janet Corrigan – The National Quality Forum – President & CEO
There is an effort going on. I mean I guess a great deal of emphasis is being placed right now on how we really begin to beef-up our set of performance measures, quality measures that can be used for public reporting as well as in payment programs going forward as we increasing want to reform payment to tie it more directly to quality and to patient outcome. The role of National Quality Forum is to endorse consensus standards, we are a standard-setting organization but for performance measures, we endorse the performance measures that are then used by many different groups within both the public and the private sector.

HITEP is a Health Information Technology Expert Panel that NQF convene. It is an effort that has been funded by HHS to essentially look at the performance measures that are being used and to then trace those down to the kind of data that needs to be captured within electronic health records and personal health records to be able to support quality measurement, public reporting and of course improvement of care which is the end-gain here. HITEP has been going through a process, initially taking a small sample of measures to identify the data types that need to be captured within records, but now in the second iteration of HITEP this has been going on for about a year and a half now, it is a much more expansive process to look at the whole gamete virtually of quality measures that have been endorsed by NQF. And to also look very closely at the work flow and not only what type of data needs to be captured but from whom and at what point in the work process does that need to be captured. So there is a good deal of work going on that is very specific to quality measurement and I'm not sure that would be captured in a clinical workgroup. Do you want to add more to that, to John who is very much a very active member of our HITEP panel?

John Halamka – Harvard Medical School – Chief Information Officer

So here the challenge is that the folks at NQF are actually not getting to the HL-7 NCPDP DX-12 level, they are saying, oh you need, from a standards perspective to capture a medication order, a medication administration, a medication was discontinued and the author of that should be doctor, nurse, patient and it should be at this point in the process. So it is a set of standards that is more of a framework for what the data is and where in the work flow it is captured, it then is handed off to the folks who are working on the more atomic data elements to say, oh you need medication, administration, date, time well that will be captured in thus way. That is the reason they are absolutely related to each other but somewhat separate.

Janet Corrigan – The National Quality Forum – President & CEO

And the quality measurement pieces are very closely related to clinical physician support because where quality measures come from, of course so the practice guidelines and the evidence base. In an ideal world where we would like to be is when we're rolling out new quality measures or standards for public reporting, we would like to be rolling out the clinical physician support in the record as well to be able to support the actual improvement process. That is kind of the context within which it is placed at this point. Now there is also, I should just very briefly mention that it is very, very important I think that we do establish a schedule and we think about when certain things are going to happen like the ICD-10 because on the quality measurement side we have an analogist problem. All of these quality measures that have been developed by many different stewards of the measurement world; they all have to be retooled. They have to be retooled with the specifications changed to incorporate ICD-10, they have to be retooled into SNOMED terminology, and they can translate into SNOMED and be read in order for this whole quality measurement piece to fit together with what we're doing on the HIT side.

Jon Perlin – HCA – CMO & President of Clinical Services

A number of terrific points. I want o make sure I, we hear the connectivity with the clinical information, here is where it is essential, my own sort of pragmatic and practical aspect is that I am a little concerned about band width because we are going to be asking both groups to do an awful lot and I think we collectively have to take the responsibility, ownership, to make sure that our work and potential subcommittees is harmonized internally so that these are things that will come back here.

In terms of these areas we have tee'd up some more specific areas, there is the opportunity to survey existing standards, the opportunity or the need in fact to identify where there are gaps and one might imagine that there are a number of levels; extrapolating from earlier discussion what would be a reasonable starting point to make real progress but appropriately paced when the world is looking to

guidance for 2011? What sorts of things are more aspirational, say 2015, 2020 etc. and how do these really meet the test? What is the contribution that actually improves care? The statute allows for the forming of subcommittees and there is an awful lot of work to do. What may be most productive is to ask the [INAUDIBLE] staff, ask Judy to query each of us on where we feel we can contribute the most and let's try to do that in the next day. Then those names, this is a FACA, indeed after the committee generally finishes we will have an ethics briefing, just a reminder on that, but part of the process is that there are various rules about submitting names etc. and those names will be submitted through our designated federal official Judy to identify those subcommittees. Does that sound like a reasonable working approach for the next steps?

John Halamka – Harvard Medical School – Chief Information Officer
I think this is a comment about scope because to Kevin's comment about how we're end to end and not just standards, those committees would talk about the standards and their timeframe, their implementation and their certification. Now I recognize that David is a policy guy and what he wants is certification is different that conformance testing. So to say that you exchange a transaction is one thing, to say that it is actually functionally change the delivery of care and the quality is another. So I think all of our committees are going to have to ask that broader question. E-prescribing fine, it is an NCPDP script transaction, ah but did you avoid medication error by doing a drug-drug interaction check with a community drug history; that is important to ask as a certification criteria.

Wes Rishel – Gartner – VP
My card is up, Wes.

John Halamka – Harvard Medical School – Chief Information Officer
Wes go ahead.

Wes Rishel – Gartner – VP
I think that in the broad break down that you started out with there is an area that was either overlooked or included by implication that I wanted to make clear but which is that in addition to assuring security and privacy and all of the things that go with security such as those that David McCallie mentioned earlier, there is the fundamental practical method of how the players get interconnected. It sort of resembles the foundation standards in the tiger team work John has been done, and I think we need to include perhaps a broad overview of connectivity at least with the security area. Privacy almost is not separable in implementation, but there is a bunch of separate concepts that need to be considered.

John Halamka – Harvard Medical School – Chief Information Officer
Wes the intent was that security would be secure messaging, transport among stakeholders, authentication authorization, auditing; all of those things including what David had suggested.

Wes Rishel – Gartner – VP
10-4.

Jon Perlin – HCA – CMO & President of Clinical Services
Let's take three comments and then we will make sure that we move to some of the public comment period, but let's take three comments. We have to close by, also adopting a schedule, that is actually a statutory requirement so we need to make sure we do that, come to a straw suggestion so we will go Jim and then Kevin and Douglas Fridsma.

Martin Harris

John, this is Martin Harris. I'm sorry that I joined late. I wondered if I could be added to the list?

David Blumenthal – National Coordinator – HIT
Martin, since it is your first. Let's do brief because we have got a bit of time pressure to make sure that we get the public comments, so you have got the last word.

Martin Harris
Okay. Is that the first word or the last word?

David Blumenthal – National Coordinator – HIT
That's the last word, we'll come to you after Douglas. So let's go to Jim Walker first.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think Dixie's response is a natural reading of the way we have got them labeled. I think if we said something like clinical operations or clinical quality it would be clearer about what we're doing.

David Blumenthal – National Coordinator – HIT
Perfect, if there are no objections to the friendly amendment. Kevin?

Kevin Hutchinson – Prematics & National E-Health Collaborative – CEO & VC
Two comments. One, to John's comments about moving beyond just the transaction, I think that is what we look at as being more where the puck is going, around medication management; drug interactions against med history, that is all about are we managing a patients medications or are we simply exchanging transactions. So I am all in favor of that out of the category of clinical. I think it was Anne that mentioned previously the category of administrative, and while probably this group is not going to take on the task of administrative standards, your comment you made earlier John, we need to at least keep in mind those administrative standards because we don't want a large gap between what we are requiring on the administrative side and new standards that are required on the clinical side and the gap becomes wider between what we are asking physicians, clinicians to do on the billing side versus what we are asking them to do on the clinical. So if nothing else I think we should add it as we recognize it is another area, not one in which this group will actually maintain other than to make sure that it is not completely out of conformance with the directions.

John Halamka – Harvard Medical School – Chief Information Officer
Just to make sure that the map includes administrative as well as these other areas, right? That makes sense.

Jon Perlin – HCA – CMO & President of Clinical Services
As the summary comes back to each of these working groups, we can put that as something that is within the preview to make sure that it is consistent, but also recognize that initially it is a separate area.

David Blumenthal – National Coordinator – HIT
Some of the focus on these three and not the fourth really take their lead or cue directly from the statute and some of the timelines that are in place. Douglas?

Doug Fridsma – Arizona State, U of A, Mayo Clinic – AP, Doctor
I have just a couple of comments and I appreciate all the good work that has gone on so far. I think the first is as we organize I hope that we approach in an enervative and incremental approach in that given our timelines and deliverables I think that is going to be a critical path way of organizing. I think we also have in the statute the need to come out with some interim guidelines and then one would assume that

eventually there would be some other guidelines that would come. So we are going to have a process in which we start with where we are now and try to anticipate where we want to go. That process is something that I think is an important deliverable if you will, from this committee because every organization out there is going to have to say this is where we are now and this is where the standards committee has told us we need to go. So we can model that within this committee to try to make sure that we have some notion about how we can get from here to there. That process I think will also help articulate how we can accommodate innovation which is again a notion of change around these standards. So I think although our committee is charged with developing standards, I think we need to make sure that we also have articulated an appropriate process that we can get out there as well. The third thing I just wanted to say is that we talked a lot about interoperability and standards and things and Chris brought this point up as well, it's that standards and interoperability is a continuum, it is not a binary process. So there is the notion of semantic interoperability, there is syntactic interoperability and there is even sort of this notion of sort of functional or work process interoperability. But that standard in one process doesn't necessary translate itself into another even though they may look the same. So I think that is going to be part of what we need to instruct our committees about, to articulate is this a semantic standard, is it a syntactic standard, are there other kinds of things that are really important and that as we build this out being clear what we're trying to address. A fax is a syntactic standard perhaps but it is certainly no semantic standard for interoperability.

David Blumenthal – National Coordinator – HIT

I just want to make one comment because I am going to have to leave a little bit early. First to Doug's comments, there are many aspects of the statute that anticipate iteration. There's first of all the fact that our December 31st rule is an interim plan of rule so it will be subject to comment and then revision. Number two; there is the escalating or changing meaningful use definition. Number three; there is the emphasis on innovation that I have mentioned so I think that is a very good theme to keep in mind that may take some pressure off you all. We have got to get started and we have got to move, we have got to meet statutory deadlines and we have got to prepare for 2011, but 2011 is not the end of the world it is the beginning and we can build on it. I want to thank all the committee members again for being here. I want to thank the public for being here. I regret that I am going to miss the public comments but for those of you who are making comments either here or on our telephone connection, we do record all of these and we make a record of them. The office will pay close attention to them. So thank you again and I look forward to seeing you sooner probably rather than you would care to be here! Bye-bye

Jon Perlin – HCA – CMO & President of Clinical Services

We're just terrific at inspiring leadership. Marty Harris is online and I want to get your comments and then we will go to one other piece of business and then public session.

Martin Harris

Sure, thanks Jon. So I really agree with the groupings and my suggestion is really related to considering a fourth group as we're moving forward and it really speaks to this iterative nature of what we will be doing and the span of time that we will be addressing with the standards which are both immediate, intermediate and even long-term as David said 2020. So I think as we're doing this work we should be considering in real time how we're going to communicate it effectively to all the audiences. And I would start with all of the three working groups being able to see something that is driving their work in common and in relative real time and then thinking about how we're going to translate that for other audiences, the general public, the provider community and all of the other stakeholders. So it seems to me that this process clearly needs a lot of technical work to be done and I'm assuming that the staff is going to knit that technical work together but making sure that we are all working towards common goals that are spread over a long period of time I think requires a dedicated effort to frame it and present it.

John Halamka – Harvard Medical School – Chief Information Officer
Marty, this is John Halamka, very good comment. HITSP started off as doing a lot of technical work and then, in its first year established the educational communication and outreach committee, exactly for your point. Taking a lot of technical standards and communicating them to a practicing physician is a great deal of work and so I think, no question we're going to have to figure out to translate all this, communicate it broadly and that may be another working group eventually.

Jon Perlin – HCA – CMO & President of Clinical Services
I'd also add, that this group itself will have responsibility for knitting together the recommendations of the three working groups and I think all of us have a responsibility for working on, not just the standards, implementation, specification certification criteria gaps etc. But the work on being able to provide a rationale and a comprehensible readily understood manner that the Office of National Coordinator as the ultimate receptor of these documents can help to communicate and promulgate which actually takes us to our last item of business which is that we need to adopt a calendar it actually is not the standard this month type of document but we need to adopt a process so I'd like to throw out a proposal, some of it, the first three parts are already in statute. The Policy Committee recommends in order of priority for development harmonization, recognition of standards implementation specification, so that's we've heard from Jodi's description, the Policy Committee forwarded those policy recommendations to the National Coordinator and the National Coordinator forwards accepted recommendations to us. So that's the general working process.

The question is how rigorous do we want to be on ourselves. We know what the timeline is that we're going to test our collective ambition so the real pivot of this, can we agree to a general working principle of 90-day turnaround typically realistic?

I'm sorry to each of the activities that we are asked to produce recommendations on standards that we provide at least a report either on standards, the ability to identify what is harmonized and useable and then identify gaps and the aspirations as a working product back after that period time, in support of…

John Halamka – Harvard Medical School – Chief Information Officer
Right, just as a comment. Policy obviously may ask us to do something that requires years of work but within 90 days we should say, oh we have looked at the environment. This piece, right off the shelf, this piece a large body of work, we will ask the Standards development organizations, harmonization organizations, certification organizations to work on it to fill the gap. So basically it is suggesting we set a 90 day time frame from policy to output of a series of recommendations, not total resolution.

Female Speaker
[audio cuts out] –nation so that we could turn quickly? I assume?

Jon Perlin – HCA – CMO & President of Clinical Services
I think we have to.

Female Speaker
I do too and that's why I'm suggesting it now for committee consideration.

Jon Perlin – HCA – CMO & President of Clinical Services
I think we can ask Jodi to come up with some final language and I think we can allow ourselves the wiggle room of typically 90 days but understanding there are some things that are monumental. And to just again gain consensus that per the statute and per frankly despite the really formidable and

exceptional skills that around this table and in the office the statute does recognize the need to receive input from voluntary consensus standards organizations and others who are the developers that we adopt a process for, input and recognize that as part of the calendar.

So Jodi Daniel has many skills but she is the person who knows the statute backwards, forward and sideways. Are we meeting the statutory requirements if we adopt those two principles?

Jodi Daniel – HIT – Director of Policy and Research
I think so. I mean I've heard folks talking about sort of a more specific road map and I think that is something that this committee can develop if in fact if that is what is desired and I do think that would be helpful for folks to give a better indication more specifically but I think for purposes of our initial meeting and initial statutory obligations, no playing the role of a lawyer but the would be sufficient for the time being with the expectation that this is something that gets updated and that we can do that as folks desire.

Jon Perlin – HCA – CMO & President of Clinical Services
So we would agree to this as a process. And I hear the road map in two different ways but one is, and I've heard this from multiple individuals and resonate with this is that there are a lot of things coming down the pipe in different channels and whatever enthusiasm there is also the need to prepare and anticipate and stage and I think that is extremely helpful.

So we've got two cards up, Jim Walker and, do you prefer Jim or James?

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

Jon Perlin – HCA – CMO & President of Clinical Services
Jamie. I'm sorry Jamie. Jim?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Quick process question, which of the three subcommittees will address the road map?

Jon Perlin – HCA – CMO & President of Clinical Services
I think ultimately that would come back here would be my sense, certainly in coordination with the National Coordinator. Jamie?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
[INAUDIBLE] the combination of this 90 day rule that we're imposing on ourselves and the idea that we're going to produce a road map mean that we have a schedule to produce the road map within 90 days?

Janet Corrigan – The National Quality Forum – President & CEO
How about we need it in a week or two?

Jon Perlin – HCA – CMO & President of Clinical Services
I think there's the desire—

Janet Corrigan – The National Quality Forum – President & CEO
How would that fit in with the talk about, I've never had a 90 day deadline in my life.

Jon Perlin – HCA – CMO & President of Clinical Services
Are you recommending for shorter?

Janet Corrigan – The National Quality Forum – President & CEO
I don't know how, is somebody going to sit down and back into our schedule and tell us that we only have a week and half to do our first task anyway? That's where I'm coming from.

Jon Perlin – HCA – CMO & President of Clinical Services
Well to be very clear, if you dissect the statute backwards, I think some of our initial work really needs to be done in the next 60 days to be able, that's, is my calendar calculating right?

Jodi Daniel – HIT – Director of Policy and Research
Right yes, like I said the statute does allow HHS to consider standards implementation specifications and certification criteria that have gone through prior processes so we have sort of a starting place and you know have been talking with HITSP about how some of the standards that have come out of that process might map to some of the areas that we might want to consider for that initial set but to the extent, particularly if there are other things that, you know if there were recommendations or suggestions from this group, if there are gaps or areas that folks want to recommend that may not have gone through that prior process, yeah I think we're on a pretty tight time frame for some of that input.

John Halamka – Harvard Medical School – Chief Information Officer
As she said there are two processes, there's the expedited process which gets us to an interim, emphasize interim, final rule for which we probably have 60 days to do the initial body of work in those three committees and then there's the normal process. And the normal process would be the typically 90 days.

Jon Perlin – HCA – CMO & President of Clinical Services
In fact, you know I think it's also very consistent with the thread, not the major theme of both the statute and all of your guidance anticipating an incrementalism that really moves things along with building on what we have and being more aspirational further out. We heard that loud and clear. Steven Findlay?

Steve Findlay - Consumers Union – Senior Healthcare Policy Analyst
No, no. Okay I think it was clarified. I mean I just assume that we're going to be, road map and a schedule is going to be oriented towards this major task of meeting the deadline of producing an initial set. That's the prioritization that has to occur, we have to be very clear about how we're going to achieve that and other things could be kicked down the road, but that's a priority. Obvious point.

John Halamka – Harvard Medical School – Chief Information Officer
Janet?

Janet Corrigan – The National Quality Forum – President & CEO
Is it correct that we're going to in the next 48 hours or whatever that we're going to try to get these workgroups constituted, maybe the next week. The workgroups when they meet, Jodi will you be able to give to the workgroup and initial mapping of existing standards that are applicable to their workgroup area so that the workgroups know what is potentially realistic for this starter set or this initial set? Isn't that going to be a critical…

John Halamka – Harvard Medical School – Chief Information Officer

Right. So I have a call Monday afternoon with all of the HITSP leadership to ask how much we can give to these committees as quickly as possible to orient them to what is the state of the art? So yes I will take that one on.

Janet Corrigan – The National Quality Forum – President & CEO
One related question then. The 90 days, the workgroups have to build into their work time to get it to this full committee to look at and for the coordination across the three workers to take place. The 90 days is that from today and the 90 days is when this full standards committee has approved the output of the workgroups and is ready to hand it over to David Blumenthal? Is that correct?

Jon Perlin – HCA – CMO & President of Clinical Services
I think your framing is very good. It was alluded to earlier, they may be some iteration on some components.

Janet Corrigan – The National Quality Forum – President & CEO
So basically the workgroups need to get their work done within 60 days probably realistically, with then a meeting of this group to sort out all of that and then we can hand it off after that rush for the sort of 90 day initial set is done and then they can return to thinking about the next iteration of this over two, three years and all…

Jon Perlin – HCA – CMO & President of Clinical Services
Exactly.

Janet Corrigan – The National Quality Forum – President & CEO
Okay, got it.

Jon Perlin – HCA – CMO & President of Clinical Services
And that is why, let's ask Judy Sparrow, we should be able to get email discussion of aligning interests, in the next 48 hours.

Judy Sparrow
Right I'll do that. I'll start working on it today and yes, absolutely.

Jon Perlin – HCA – CMO & President of Clinical Services
Terrific. Let's see, Jim, did you, is it new or is it…?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
It's new.

Jon Perlin – HCA – CMO & President of Clinical Services
Okay. So let's go to Gina and then Jim.

Gina Perez – Delaware Health Information Network – Executive Director
I just want to make sure that when we are looking at the composition of the committees that they have good representation of real life meaningful users so that we bring that perspective always to the table.

Jon Perlin – HCA – CMO & President of Clinical Services
Absolutely, well said.

Jodi Daniel – HIT – Director of Policy and Research

And let me just say one thing on that point, if in fact the Chair and Vice Chair want to, or other members of the committee want to suggest folks who are not on this committee who have an expertise that you don't think, that you think needs to be represented on one of those workgroups that is something we can consider. It is in the charter to allow for folks, for augmentation of the workgroups with other experts or to bring in others to just testify to the group as appropriate so you can let us know that.

Jon Perlin – HCA – CMO & President of Clinical Services
Thanks. And again as a FACA committee there are some rules to government process but you say that the statute was very clear in its intent to make sure it was important as possible by as broad as possible group. Jim?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Very quickly I want to support Anne's contingent. I think the road map is going to be our reality orientation and we at least need a first draft as soon as possible so that the rest of what we're considering makes some kind of beginning sense, if not final as we're doing it.

Jon Perlin – HCA – CMO & President of Clinical Services
I think we hear a repeated theme and I understand the pragmatism in that interest.

Jodi Daniel – HIT – Director of Policy and Research
Can I make a process recommendation? Given the statutory deadline, based on a conversation we have had here, perhaps ONC can take the responsibility to try and draft something up and run it by the Chair and Vice Chair if folks agree to that and then as I said this is something that can be updated and revised as the committee sees fit so if that's okay we can try to expedite that process.

Jon Perlin – HCA – CMO & President of Clinical Services
I think that's terrific and you know I think one of our tasks is to be sure that we leave enough platitude for the National Coordinator that they can work effectively in this space and so I know when I'm running a project that I want a road map that's really got the critical path for every thread and every dependency and that may not be the first iteration, our first iteration may be broader conceptual terms and areas and if, than have consensus around the general issue of our self imposed expectation of 90 days, the reality of the statute that governs that and a process below that. Anne?

Anne Castro – Blue Cross Blue Shield, South Carolina – Chief Design Architect
I would like to volunteer to give you a copy of a road map that has been very effective in our work that kind of is at a glance at that highest level that helps you see what your major industry and you know impacts can be. But I would also like to recommend that each workgroup, their first task be to create their road map that they're going to sit down and create a task list. They have to because that is your list of what you have to accomplish and it will be obvious for your task what your critical paths are. So that you can create the same thing and then we can all see that we are all drilling to a similar check point and then we can look at those things that cross two different areas and know when our coordination responsibility is.

Jon Perlin – HCA – CMO & President of Clinical Services
Two excellent points, Anne. There is a process for submitting information and I want to make sure it is available to all on duty, would receive a model that you would offer and the second yes in each of the workgroups thinking about not only the road map but harking back to as we mentioned a little earlier, what is available 2011, what gaps currently exist, what might be envisioned further along given the wisdom that we have heard about building over time and importantly how does it improve care of

value, efficiency, all of the attributes that really are the fundamental. Let me stop and see if there are any comments from my Co-Chair, John.

John Halamka – Harvard Medical School – Chief Information Officer
No, I mean you have outlined the process quite well and that is we will break into these committees, these committees will be done virtually. We want to be green here, we want to minimize travel. I know how much you enjoy airports so the use of WebEx, the use of the telephone, the use of e-mail, this will be the primary way we work. I also know you have day jobs and so we obviously try to do as much of this work asynchronously as we possibly can and come together for very efficient calls and as was stated, we will have to come up with initially how will these committees, who will lead the sub-committees, what their tasks will be and ONC, I am sure will give us, not only a map but that date based guidance so we understand the deadlines for those task lists to be completed.

Jodi Daniel – HIT – Director of Policy and Research
I will be very quick. I just want to thank everybody for coming and for all of your dedication in advance. I think this is going to be both a challenging set of issues that we are going to have to address and also I think can have a great deal of impact on our rolling out of Health Information Technology toward our larger goal of healthcare reform so thank you very much.

Jon Perlin – HCA – CMO & President of Clinical Services
Thanks for that. We will work on a very practical level on schedules trying to accommodate as many people as possible but obviously we are going to have a number of the workgroup meetings virtually thankfully in the very near term and hopefully, but expect bring back the initial discussions and the threading together at the next meeting. Lets turn now to public comments. I appreciate everyone's patience and everyone's interests. I would ask if you would please be so kind as to state your name and your organization and Judy?

Judy Sparrow – HIT – Director of Programs and Coordination
Can I just say one thing. Chris will open up the lines for the public and there will be a telephone number and instructions on how to get on the line and meanwhile those in the room that wish to make a comment, as you are doing, stand at the microphone. But also I wanted to say, I am so sorry this morning, we obviously had a much greater interest in this committee and a much smaller room than necessary so we apologize for anybody being turned away and we will work very hard not to let this happen again. So are the public lines open?

Operator
For those of you that are following along online the phone number and instructions are right up on the screen. You can dial in 877-705-6006 and then press *1 to ask your question and to make your public comment. If you are already on the phone line just go ahead and press *1 to queue yourself up to make a comment and while we are waiting for folks, Judy, why don't you guys start off in the room.

Richard Eaton – Medical Imaging and Technology Alliance (MITA)
Terrific, good morning. Thank you for the committee for all the work that you are about to do and this is a really important project. My name is Richard Eaton, I am from the Medical Imaging and Technology Alliance (MITA), which is a medical division of the National Electrical Manufacturers Association. We are the largest US trade association which represents the electrical industry. Our medical division represents over 95% of the global market for diagnostic imaging equipment. There is really no doubt that interoperability of systems is absolutely crucial and you can not have interoperability of systems unless you have interoperability standards. I want to tell you a little about MITA's experience in this area. We are the leader in terms of development, deployment and testing and also protecting the

integrity of DICOM which is going to be a standard you are going to hear plenty about. We are also involved in the HL7 standard and in integrating the healthcare enterprise these are areas in which we are very involved. A lot of these standards are, to a great degree, implemented already. Many are implemented in a lot of different countries. I want to emphasize that you have terrifically huge time pressures here. Let us be your resource. We have been involved in standards development activity for over 80 years and we can be a great help to you. One, also comment I wanted to make about diagnostic imaging. I do not think there are any arguments that it is a key part of the electronic health record. Our association has developed standards for almost all imaging modalities. We can be of great help there as well. So please do not hesitate to call on us and we are glad to help. We share the same goals of NHIN success and interoperability is absolutely essential to that. So I thank you and look forward to working with all of you.

Jon Perlin – HCA – CMO & President of Clinical Services
Thank you for your comment.

Michael McGrath – Gemalto
Hi, good morning. My name is Michael McGrath, I'm with Gemalto. We are a world leading digital security company and I appreciate the opportunity to be here today and be able to provide some comments. I heard a bunch of things today which were of great interest. A couple of things to note I heard the words patient centric, authentication and setting the bar. And I am sure everyone in the room is aware, recent polls show that consumers are generally very much in favor of having an electronic health record and hopes that it is going to improve care. But at the same time they have serious concerns about the privacy and security of their health information. If the bar is set too low as it pertains to authentication it will not address the public's concerns. Authentication typically is done by username and password. Although that is widely adopted it is not secure and it's easily compromised and it does not to provide the trust as David had mentioned earlier and the high assurance that the person accessing the data is who they claim to be. So hopefully as you guys work together, stronger authentication techniques will be deployed to access my medical information and everyone else's in this room and the country. Thank you.

Jon Perlin – HCA – CMO & President of Clinical Services
Thank you very much for those comments. Lets go to the phone lines. Judy Sparrow I will let you.

John Halamka – Harvard Medical School – Chief Information Officer
We actually have about 4 people queued up for questions right now. Ryan, do you want to put the first one through please.

Jon Perlin – HCA – CMO & President of Clinical Services
Please, first comment.

Operator
Yes, our first comment from the line of Philip Barr with Thompson Reuters.

Philip Barr – Thompson Reuters
Good afternoon, thanks for taking the call. I just want to state that, as you know, there is a great deal of anticipation to what this committee is going to come out with both from the standards committees who you are supposedly taking charge from what your doing and with the greater healthcare and health system community so I would like to say that the road map that was talked about is hugely important and would like to offer some structures which we have been working on and we have vetted with the National Library of Medicine, vetted with many of the folks in the standards organization as far as

tracking what is going on in this field, what are the spaces and the direction that things are going so we would like to offer to participate and help in that area. I would also like to ask a question of the brain trust there, all the folks that I know in that group and what I hear up on this call, extremely competent and the right people that be there and I just would like to hear just some sort of feedback if possible or at least for you to think about for the next session, maybe in 30 days which you are going to be offering, is what would be, do you feel that what you need to have for that first step, I know that it is an innovative process and you are going to be going through many steps but that first step, the very important first announcement that you make of this is the priority for the number one, do you have a sense that we know where we want to go with that and there is probably, maybe different view points on that but just some sort of feedback from the committee.

Jon Perlin – HCA – CMO & President of Clinical Services
I, first let me thank you for your comments and I think they are really do not want to presuppose the process and the work that is going to be done or really would have to defer questions of that sort to the Office of the National Coordinator at a different time.

Philip Barr – Thompson Reuters
Great.

Jon Perlin – HCA – CMO & President of Clinical Services
But I do look forward to our ongoing work. These obviously are the sorts of issues we we'll be addressing.

Philip Barr – Thompson Reuters Martin Harrison
Thank you.

Judy Sparrow – HIT – Director of Programs and Coordination
Will we take another one from the phone?

John Halamka – Harvard Medical School – Chief Information Officer
Ryan, could you please open up the next one please.

Ryan
Our next comment comes from the line of Joseph Conn with Modern Healthcare Magazine.

Joseph Conn – Modern Healthcare Magazine
Hello, Dr. Perlin if you could just make to sure that I have it correct go over the three workgroups. I have got clinical operations, clinical quality and privacy and security as the three, is that what the final word is on those?

Jon Perlin – HCA – CMO & President of Clinical Services
Those are the three workgroups that are being formed.

Joseph Conn – Modern Healthcare Magazine
Very good, that is what I wanted to know.

Jon Perlin – HCA – CMO & President of Clinical Services
Thanks.

Judy Sparrow – HIT – Director of Programs and Coordination

Ross?

Ross Martin – Deloitte Consulting
Good afternoon, thank you. Ross Martin with the Deloitte Consulting. As you pull back the lens on high tech and healthcare there is also the lens of the Recovery Act itself and the reporting requirements around there for transparency and reporting on outcomes and all that on the larger stimulus package. And then of course, if you pull back again there is the whole global arena where similar things are going on. And so one of the questions I had for the committee is whether or not the purview of this committee will include how we are going to do reporting for stimulus funding like incentive moneys. There are a number of standards right now competing for that and then I think a lot of the questions have not been answered around that between like the National Information Exchange Model that has been promoted by DHS and in the financial community the XBRL, eXtensible Business Reporting Language and are we going to do a healthcare specific approach to that or are we going to incorporate that into the larger question?

Jon Perlin – HCA – CMO & President of Clinical Services
Refer to Jodi Daniel for comment.

Jodi Daniel – HIT – Director of Policy and Research
Yeah, this committee is a Health IT Standards Panel so I think sort of the broader questions you are asking are probably outside of the expected purview of this committee. If, you know I would be happy to talk to you offline if I might be misunderstanding your concerns.

Judy Sparrow – HIT – Director of Programs and Coordination
Dr. Zuckerman?

Allen Zuckerman – Council on Clinical Information Technology
I'm Allen Zuckerman, Practicing Pediatrician on the Council on Clinical Information Technology, American Academy of Pediatrics and I represent as Co-Chair of the interoperability workgroup at CCHIT. I just wanted to appeal strongly to you not to leave children out of your initial standard. The act identifies children as a vulnerable population not just because of their health and social vulnerability's but because they are in danger of getting left out of Health Information Technology because the kids you can see sitting across the hall in the daycare center are not in the room here speaking up for themselves. We have in the CHIP Reauthorization Targets two important targets identified in terms of immunizations and also identification of obesity. We also have the opportunity to 4 million newborns who get discharged from hospitals each year. In the list of components of your clinical list that I heard I did not hear about the gross data and I did not hear about the vaccines, the labs will of course include some of the newborn screening and other things. Please keep kids in your minds are you go forth. I did hear some response to the bankruptcy of the Chrysler Corporation in terms of your awareness that products that are out on the market and do not get used or vulnerability who we also need to limit the number of models in our standards but in terms of innovation there are two other important lessons from the car industry. Imagine if you moved and you could not take your car with you and imagine if when you got ready to buy a new car you could not pick out whose car you wanted to buy. You made some very important statements in your meeting today about the importance of structuring these clinical lists, discreet data that has to move and some of the narrative data that has to move. In terms of the long-term road map, we should reach a point because that is what the doc's practice expect, that two certified EHRs should be able to exchange patient data and that some day physicians should have a choice in their purchasing.

John Halamka – Harvard Medical School – Chief Information Officer

So as a committee we will all aim to be Prius drivers, no problem. But Allen to your point a part of the briefing that will arrange for the committee includes a, looking at all the HITSP work that has been done to date and mapping it into vulnerable populations. Actually I have a tiger team working on that so you will be briefed.

Jon Perlin – HCA – CMO & President of Clinical Services
Please let the record know that the Chair is married to a pediatrician and that if this is not addressed, there are more serious consequences. We have one more call on the line.

John Halamka – Harvard Medical School – Chief Information Officer
Ryan can you go ahead and open up another question.

Operator
Our next question comes from the line of Fred Buhr with Metasteward.

Fred Buhr – Metasteward
Yes, my name is Fred Buhr. I am a former employee of the State of Wisconsin. Back 10 years ago I worked on the HIPAA implementation and at that point I also was a member of the HIPAA Metadata registry correlation. And I recognize people who are working on the current situation as people who had worked at that point. I recognize Chris Chute and I recognize some of the people who are part of your USHIK team at this point. And the point I want to make is that the semantic interoperability as Chris has mentioned is very important both at the human level and also at the machine level. Back in 1994 when the web was being developed, the author of the web mentioned the semantic web, which is machine to machine. Both levels though, the human level and the machine level are built upon logic and essentially at the human level its symbolic logic, at the machine level it is a deeper level of logic and so taxonomies, ontologies and so on are very important and so I would suggest at the outset when I worked on the Metadata Registry back in when HIPAA was being implemented essentially I loaded it from the bottom up but I am suggesting is that at the outset you involve your USHIK team and identify the concepts that you are looking at right at the beginning of this process. Thank you.

John Halamka – Harvard Medical School – Chief Information Officer
I am happy to respond to that and that is HIPPA has embraced USHIK which stands for United States Health Information Knowledge base hosted by AHRQ Michael Fitzmaurice is in the audience and has been a real champion of us using that as a repository where we talk about data elements and functionality. USHIK has been a tool for all the HITSP work to date. So certainly that recommendation is very appropriate.

Fred Buhr – Metasteward
I would like to also volunteer as an older American to serve in terms of any feedback as a real live use case.

Jon Perlin – HCA – CMO & President of Clinical Services
Thank you very much for your comments and volunteerism. Well I want to thank the entire group for participation today. I want to thank to start by thanking the public which stood by online, on phone and in the room. Thank you very, very much. As you, I think the statute is very clear that this is very open process and I want to thank the members of the committee who traveled, really made this a priority on short order and are making a very serious commitment of time over the next few months initially to meet some of the requirements that are before us. I know that everyone in this room is driven by a recognition of the current shortcomings and a passion for resolving those to deliver a safer, more effective, more efficient, more accessible healthcare. I would, before I do adjourn the meeting formally,

I do want to let the members of the committee know that we need to stay as part of our Federal Advisory Committee Act on requirements we have to complete our ethics training on this and I want to, I think everyone should acknowledge the great work of Judy Sparrow, our Designated Federal Official and the staff of the Office of National Coordinator who have just gone to [INAUDIBLE]. And with that we stand adjourned. I'm sorry John?

John Halamka – Harvard Medical School – Chief Information Officer
Communication is going to be absolutely key as we go forward in this process so I am on e-mail 21 hours a day. Send me an e-mail about any issues or concerns. Thanks.

Public Comments Submitted via Text:

I am the IT Director at Chambers Memorial Hospital, a rural Arkansas hospital. Please work with both integrated HIT software vendors, and a diverse group of providers as our motives are different.

Although most of the participants in this committee and consultants calling into this conference claim altruistic motives to facilitate increased patient care, their motives are to increase value to their firms for the shareholders of their companies. There is great opportunity to take advantage of providers with no skill in these fields.

For example, to allow viewing of clinical data from a hospital that I am transferring a patient to with my current HIS, I am required to purchase a license for that referring physician at $1300.00. Licensing kills us in capital and expense costs. I would like the ability to have a national repository on the internet and a standard language to dump an export from my software and let the accepting facility go out and pick it up.

The most helpful item to address in the rural areas is bandwidth to maintain interoperability for internal operations and external transfer of data. It is common in most rural areas to have only DSL available at 1.5mb which makes day to day operations difficult for the doctor's working at different clinics and facilities. We desperately need clarification and direction as to how and from whom can we obtain support from the stimulus package to get the infrastructure in place before EHR meaningful use is possible in rural America.

We hope the work group will consider including immunization history exchanges. The standards are ready. Nearly every state has a registry with histories. This is important to health reform and is essential to Quality improvement and healthier communities. This can be an early success and individuals and the community will benefit.

Will the Component Committee be responsible to define vocabulary standards? Quality Committee must solicit members from all current healthcare Quality Standards organizations NQF, Medicare's PQRI, NCQA, JACHO (patient safety) >> assuring Patient Outcomes, incidents, and negative impacts are included.

Will the scope of the standards include both the exchange of health information as well as administrative data exchange to harmonize data standards between administrative data use for treatment of patients (claims data for developing problem lists) or patient demographics that are important for patient care. One of the administrative records that is often requested is ethnicity,

language spoken, primary care assignment, and advanced directive information. Will scope of the committee address the standards for exchange of this information with EHR databases?

Didn't hear much about technology certification criteria or recommendation for enforcement guidelines. Thoughts?

As it relates to certification or qualification will the standards preclude state or Medicaid program specific EHR certification standards or requirements. In other words is it the intent that federal HIT standards will override states setting more prescriptive or restrictive EHR certification standards.

I would like to make the following recommendations to the committee:

- That each workgroup created look at those delivery systems both inside and outside the US that have the highest documented clinical outcomes in determining recommendations

- Make sure you are looking at both critical access and non critical access hospitals and the work they have done to implement advanced clinicals; someone mentioned earlier in the call that some hospitals may only have

IT staff members - again seems to be a lack of knowledge of the more than 1,000 critical access hospitals in the US as they very often only have one IT Director and by the way, they may also be the DON or CFO.

Will the committee also develop a process roadmap for "new" standards requirements to reach implementation? I.e. how will new standards make it to and through the certification process, then to vendor integration, then to practice implementation and training? Keeping in mind the 2011 (October 2010) endpoint.

There are existing private-sector solutions in the market today that address some of the standards/innovative processes you've discussed. How/will these solutions be considered?

How specifically will the work of the HIT Standards Committee be coordinated with the work of the HIT Policy Committee?

How will the Standards accommodate state or Medicaid program standards that may be more prescriptive or Medicaid program specific standards in areas of quality outcomes or system interface requirements that are important to state Medicaid, Public health and disease surveillance. For example, a state public health may want to establish an interface standard for semantics or interface performance standards for public health data exchange. Or a Medicaid program may want to use existing quality standards to overlay on EHR meaningful use or quality outcome.

I wholeheartedly agree with the gentleman who suggested a fourth working group focused on education and awareness!

This committee needs to spend more time to engage the public in promoting EMR/EHR/PHRs.

How can a few interested folks participate in sub-committees to help create drafts that then could be reviewed by the HIT standards committee? I am interested in participating if that would help committee's work.

What other existing standard-setting organizations will the committee consider for recommendations? (Other than HISTP)

How will the other national health architecture initiatives like NHIN, PHIN, HITSP, etc. align, leveraged and brought under a common framework?

Regarding Quality - I encourage the committee to support the work that NQF has undertaken to produce a standard for quality measure expression: HQMF - the Health Quality Measures Format. Without this - we can't properly define quality measures for "digestion" my EHRs

HIT standards are key for HIT/HIE, how will committee determine priorities and key focus areas - as this is complex and very large area?

As a vendor, I am concerned that there is a perception that a soon as a policy and standard is established vendors will completely support them. The reality is vendors need time and will need to expend capital to meet these needs. What allowances or support will be provided to vendors to achieve the required changes?

Is the goal that physicians and hospital's qualify for payment as early as possible or that our providers are motivated to get aggressive towards adoption of HIT? This is basically a question challenging what drives the policy and standard recommendations and how much stretch should be required in them.

Will the standards committee consider interoperable proof points like IHE or are we re-inventing the rules?

e-prescribing, laboratory information exchange, clinical summary and quality are certifiable criteria that if implemented and used according to intended design and that is measurable in success/failure terms whether "Meaningfully used".

Beyond text reports, sharing of the patients images would be greatly beneficial.

Immunization history is also frequently mentioned as an opportunity for exchange

What the IRS replaced the Fax with was PDF in 1991, so we might look to AIIM for a PDF for Healthcare standard

Will this committee also address the administrative issues that lead to health care waste? Physicians spend three hours per week—43 minutes on average per workday—haggling over claims, credentialing, authorizations, formularies, and other issues with health insurance plans, according to a study recently published. The Costs to Physician Practices of Interactions with Health Insurance Plans found that total staff interaction time system-wide converted to dollars equaled $21-$31 billion annually—an average of more than $68,000 per physician per year. It would seem that standards here could greatly reduce that cost...

Certification does determine whether the application meets the requirements that would guarantee that if used appropriately it would lead to measurable success if used adequately and according to its design.

CCHIT has a comprehensive set of criteria that does guarantee a validation of a product that can meet the "Meaningful use" concept.

If our goal is to make healthcare more effective and efficient (and thus constrain costs), we must ensure our standards are very concise and efficient (lean and mean). HITSP's current morass of Interoperability Specifications represent an obvious example of what not to do and how not to do it.

'Meaningful use'' has nothing to do with certification, harmonization or standards compliance. ''Meaningful use'' should be a metrics based process to determine if an EMR is being used with significance. Just because I have an EMR that is certified, harmonized, and compliant does not mean it is given ''Meaningful use''.

How will standards be inspected that they are interoperable before they are passed to testing and implementation?

I am concerned that it seems there is "under representation" (as compared to "industry") of individuals and their perspectives with regard to the use and control the electronic records which will be created about their personal health?

Standards work only if they are followed by everybody whom they apply to. I wonder if and how the use of approved HIT standards will be enforced?

There are a few organizations working on standards for HIT, such as HITSP, HL7, ASTM, who sometimes have different concepts, approaches and processes. Will the Health IT Standards Committee coordinate and steer their efforts?

Will the Panel be able to address the question of certification and "meaningful use" for hospitals and departmental systems versus the enterprise primary system? Will the various departmental systems have to be certified (and, except for the Emergency Department, no such certification process exists in CCHIT today)?

If a state decides not to take ARRA funding to support a Health Information Exchange (HIE), can an existing HIE entity receive funding directly from the office of the National Coordinator?

What the role of the Standards Committee is as compared to the recommendations from NCVHS as compared to what ONCHIT will do?