

Vocabulary Task Force Draft Transcript September 23, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to a meeting of the Vocabulary Task Force. This is a FACA Committee Meeting, so there will be opportunity at the end of the call for the public to make comment. Let me do a quick roll call. Jamie Ferguson?

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

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Stuart Nelson?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marjorie Rallins?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

John Halamka? Stan Huff?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Chris Chute? Dan Vreeman?

Daniel Vreeman – Regenstrief Institute – Research Scientist

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

John Klimek? Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Trudel? Don Bechtel?

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

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patty Greim?

Patricia Greim – VA – Health System Specialist: Terminology

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Walker? Andy Wiesenthal? Doug Fridsma? Bob Dolin? Amy Gruber?

Amy Gruber – CMS – Program Analyst

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Lisa Carnahan? Lynn Gilbertson? Nancy Orvis? Marjorie Greenberg?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anybody off? You should have all received the slide set from Jamie's presentation the other day at the Standards Committee. With that, I'll turn it over to Jamie.

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

Thank you very much, Judy. Actually, Betsy and I together presented these slides and these are the same ones that went out to you, I think a couple of weeks ago. I did get a few comments back and updated the slides based on those comments from the Task Force members. So we did have, I think, a very good and productive discussion with the Standards Committee and I'd like to just go through the slides, both, to see if there are any questions, as well as just to frame our discussion here today.

Is there anybody who does not have the slides in front of them? What we'll do is I'll go through and I'm sorry I'm not on the Web portion of this meeting, so I'm just walking through the slides separately on my own.

The first slide is just a listing of the Workgroup members, or slide two. Slide three is just an overview of the major questions that we asked during the hearing and just saying that we had a bunch of detail questions as well. Slide four reviews the structure of the hearing. We did end up having 24 panelists by my count.

Then, starting with slide five, a review of some of the major themes that came out of the hearing. We did hear, certainly, people asked for both simplicity and harmony in standards that would be available ... and derivative works that would be made available from the one-stop shopping facility. But we also heard that for the government to be clear about what they need to do is actually more important than it being simple and not just what they need to do, but what the one-stop shopping needs to do. In other words, they really expressed that there's a need for understanding what's required of them, how they're supposed to use the infrastructure to do it and to have a sense of predictability so that they know what the roadmap is, they know where things are going and so things don't change every five minutes kind of thing.

We also had a discussion about simplicity for the users, who are implementers of EHR technology, as well as vendors, who would be presumably downloading the vocabularies, value sets and cross maps from the one-stop shop. They wanted things simple, but at the same time, because different users and implementers have different needs there have to be mechanisms for handling exceptions.

We also heard, I think, that there should be a comprehensive plan along with this roadmap, but that that doesn't mean everything has to be done all at once. There were a few things that were called out as

needing to be prioritized. I would say overall we heard that there should be a mechanism for setting priorities that would determine which value sets need to be made available immediately, but a few things, such as the cross maps for SNOMED CT and the need for making extensions to vocabularies for rapid additions when they're needed by value-set developers is also something that we heard.

Then we certainly heard from every panel that IP issues could represent a significant barrier to adoption. We'll come back to that in a minute.

Going on to slide six, the second page of major themes: We heard from many of the panelists that version management is absolutely critical and having clarity about what versions, both are used and need to be used when, and we heard some support for the idea of expiration dates being attached to particular artifacts. There was a theme of sort of the system infrastructure characteristics needing to be defined, such as availability, up time, system performance being adequate and a few of the panelists went into specific solutions that they would recommend for that, such as use of cloud technology, load balancing techniques or distributed systems.

Then we also heard, I think very clearly, that simply having an enumerated list of codes is insufficient for any implementation of any value set—that the context of the value set, its intent and a full description of it is important and is absolutely mandatory in some form at the time that the value sets are made available. There was also some discussion in the hearing about off-label use of value sets sometimes being valuable and needing to have information about that, about appropriate off-label uses, but also we heard some examples of off-label uses being highly problematic, so the upshot being that value set context and the intended use really needs to be both, documented consistently and made available for appropriate understanding for the initial implementation, as well as ongoing use.

Then while there were a variety of opinions expressed about ownership of value sets, there was some variation there. There was, I think, a strong theme also of having the need to have sort of cross cutting, multi-stakeholder involvement across the spectrum of potential users and sources of input and value to the value sets that would be facilitated somehow by the one-stop shop. I think this was particularly true in terms of the review of different content sets. While some folks expressed the need for there to be a very broad based involvement in development of value sets, I think everyone really agreed more that there should be a review process that was very broad based. So those are some of the major themes.

I want to get right into the focus on intellectual property, which took up a lot of our discussion in the Standards Committee. Every one of our panels in the hearing said that IP restrictions and licensing can be a barrier to implementation of these vocabularies and value sets in the meaningful use program, but basically, everyone had different ideas about what that means. I thought it was very interesting that we heard from X12 and HL-7, as well as others, that the potential impact of the licensing requirements and IP issues is not just about the vocabularies themselves and the value sets, but it's also about the messaging standards that may use or transmit them. It really broadened out the scope of the IP issues very rapidly. So, despite the potential for there being issues, we also heard from hospitals and clinicians on the panels that this just has to be made simple or it's going to be, potentially, an insurmountable problem for implementers and folks who want to get the incentives under meaningful use.

Going on to slide eight: These were from my notes of what folks said during the hearing. I think that certainly there's been a desire for national licensing that we've heard, I think, previously from providers, particularly that they want to have these things made available at no cost, but we also heard that folks are used to paying a fee. They understand the need to pay a fee for standards, but it just can't be complicated. If you tell people if you're an eligible physician or hospital in the meaningful use program and you want to apply for the incentives, sort of what's my bill and where do I send the check is sort of the bottom-line. They just don't want to be bothered with tracking their use of potentially different IP from different sources.

In the Standards Committee we floated this idea that the government could have a role in essentially administering payments to the owners of the IP from the meaningful users as an alternative to just straight national licensing or other potential solutions. So I think that a lot of the Standards Committee

members felt that there really needed to be a cost benefit analysis of this approach, because the potential cost and complexity of this kind of administration could even outweigh the cost of simple, broad, national licensing paid by the government for the IP that's used in meaningful use.

So that's what I'd really like to focus our conversation on here. I guess, certainly, I welcome thoughts and input from folks who were in the panel, major themes or anything that I missed or that Betsy and I missed in doing this summary, but I really wanted to focus our conversation here today on what we heard back from the Standards Committee, which sounded as if there were really sort of two alternatives that should be considered and that a cost benefit analysis should determine what's the cheapest approach. One alternative is what's proposed here. That there should be a government function that would administer payments of the IP that's used in the meaningful use program. The other alternative is just license it. So I'd love to get input and feedback.

Clem McDonald – NLM

The way I heard the thing about not caring about the payment was from the vendors. It wasn't from the individuals. I'd have to be corrected; that they said they don't mind paying, but they can't be charged at the distal end through their customers because it's too hard to manage. That's how I heard that.

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

Right. We did also hear that from the vendors. Absolutely.

Clem McDonald – NLM

I mean I didn't think we heard it from the individuals, but I'd be corrected. The vendors usually pay for it. It changes the complexity.

M

I thought there was one testifier, who was just a doc in his office. I can't remember who it was that basically said, "We pay fees for everything. It just has to be simple. We need to know who's paying."

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

Right. That's what I'm remembering.

Clem McDonald – NLM

All right. All right. I take it back then.

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

So how do folks feel about these being the alternatives that we would potentially recommend for consideration? I think the feedback from the Standards Committee then is that in order to make this really work from an implementation standpoint for the eligible professionals and hospitals, in order to make it simple there really just needs to be an analysis of what are the cheapest of these two alternatives that would proceed. I mean there were certainly some folks on the Standards Committee, Dr. Halamka in particular felt that this administrative approach was the practical way to go, but others felt very strongly that a really detailed cost analysis needed to be performed because this kind of administrative function could get very complex and very extensive very quickly.

Betsy Humphreys – National Library of Medicine – Deputy Director

Jim Walker was one of those, who thought that in the end it would turn out that the cheapest way to deal with this whole issue would be just license the stuff and make it available from the federal government. I just want to bring up an issue. It's true that you can say there are tremendous complexities here because it is absolutely true that you can define who is the subject of the meaningful use regulations. They are eligible professionals and eligible hospitals and so forth, Medicare and Medicaid. But the problem is that meaningful use involves the exchange of information between those people and many other parts of the health system including, obviously, potentially, providers that don't regard themselves as being Medicare or whatever and the public health system and the HIEs and all of these other things.

So going back to when we weighed various options for the original SNOMED deal and the notion of who would be in and who would be out, keeping track of this and then ending up in a situation where only a fraction of the people who needed to exchange information with other people actually had this steadily, easy way of getting access to these things argued in favor of just a license that covered everybody. I do think that a careful analysis of this issue might well show that you were, in essence, setting up something that was very expensive.

The other issue is we literally tried to work through how you would verify, how you would exclude people, how would you include them. What would happen when people went from one category to another? Would they stop using the thing? I mean it did seem like, to us, a nightmare.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I would just like to second that. It seems to me that it's fraught with a lot of difficulty along with the things that Betsy said. I mean the way that the terminology sources might want to license could be different, so some of them might want to license based on the size of the institution. Others might want to do it based on the number of CPUs that people have or some count of the number of transactions it's used in. The variability in how it might be licensed, I think, would be difficult and how you would determine that information and have it be accurate and fair; it just boggles my mind how you could administer that effectively.

It also occurs to me that there are at least two issues operating here. One is sort of the simplicity and stuff. The other is you want it to be easy for people to use, which is one of the considerations. The other consideration is who pays. Should this be funded through the government, through our taxes, if you will, or should it be funded by the users? You can imagine sort of a middle ground here where the government, in fact, set up the license agreement, if you will, but it wouldn't have to be for free. Then there could be a cost for downloading the amounts, but it would be based on a national license or at least where the cost was set through a national negotiation rather than having different kinds of agreements that somehow got administered individually for each—

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

Right. Right. That's a great point, Stan. I finally got on-line, so can I ask for the slide to be advanced to slide eight, please, on the Web?

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I want to say that Stan said exactly what I was about to say; that you don't want to depend on individual license negotiations that somehow the government is just the fee collector for. It's got to be a national license that then the government can recoup from the users on the basis of user fees, the cost of those national licenses.

Betsy Humphreys – National Library of Medicine – Deputy Director

Although that is also truly a dreadful idea in my opinion.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Well, one agrees that—

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

I agree.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

It's not necessarily a great idea. On the other hand—

Betsy Humphreys – National Library of Medicine – Deputy Director

It's much better than the other. I agree.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I read this morning in *The Washington Post* about the new Republican contract with America and the \$100 billion reduction in non-military spending by the federal government. I'm just wondering where that's going to come from and how the government is going to take on new things, like national licenses, in such an environment.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

But Stan's point, if I were to generalize it to this fee model, more or less still stands in that while it's not a per-CPU or per-use question any longer, it does become a per-context. Many physicians in this country are affiliated with more than one hospital. Is it the hospital that has to pay the fee? Is it the physician? Does the physician have to pay a fee for each hospital that they're using it in? This starts to hurt the brain as to how such a fee would be fairly characterized.

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

I think that within the context of the meaningful use program and its defined boundaries of eligible providers and hospitals I think you can imagine a way that those issues would be dealt with for that particular community of users, but I think that, as Betsy points out, that doesn't include those with whom they're required to exchange and share information.

Clem McDonald – NLM

The question we ought to ask is I don't count a whole lot of existing code systems that need money. It may be easier if we would propose this in a way that would encourage everybody to say, "Now pay me." If we only have a couple it would be nice if somebody along the line could enumerate where we think there may be—

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

Right. But I think also, Clem, we're talking not just about the taxonomies themselves, but we're really also talking about the cross maps between those that may be free and those that may not be free. We're also talking about value sets.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Clem, I think the real volume issue here is if you look at a lot of the administrative value sets it turns out a lot of those are owned by X12 or HL-7. While HL-7 has a policy of making its value set publicly available, there is the context in which they're used. So the message is not, strictly speaking, publicly available. To my knowledge, X12 has not made its value sets publicly available, so you get actually scores and scores, if not hundreds of small value sets that are entangled with these intellectual property issues.

Clem McDonald – NLM

Thank you for reminding me of that.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

The other issue that again raises its head in this context—and I don't know if there is a solution for it—but it is that to meet meaningful use and really within the purview of the U.S. we just need to license for the U.S. But just licensing for the U.S. leaves problems unresolved for HL-7 and other international standards organizations because, again, the lack of sort of a worldwide license for the use of SNOMED continues to be an obstacle in HL-7. Whenever you ballot HL-7 and you propose SNOMED, even though it's the most logical, by far, solution, objections are raised by countries that don't have a national license. Again, it may be irresolvable because our purview really, and our responsibility is just for the U.S., but I'd just point out that it doesn't solve all problems for sort of international cooperation and international standards contexts.

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

Well, I think let's work with a couple of ideas that I've heard here. In the first place, just for grounding, my assumption is that we're going to want to make some recommendation on this issue to the Standards Committee coming out of the Task Force. Does anybody disagree with that as our objective here?

It seems to me that our recommendation certainly could include, as was discussed in the Standards Committee, a recommendation to evaluate a couple of different alternatives in order to understand the most cost effective and efficient way to proceed. So certainly, I think at one end of the spectrum of what's under discussion is national licensing by the government that would make the IP that's used in meaningful use, in the entire program, free to the country. Does anybody disagree with that as being one alternative?

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't, of course. But one of the things that I think we may want to factor into our discussion and into background for any recommendation is to look at this whole issue potentially ... of how these things have in fact been handled elsewhere in the health system in terms of administrative transactions and so forth. ... not new ground for the federal government to support the ongoing development and maintenance and availability of some of the key classifications and code sets used in health transactions. I mean there are a few exceptions, but they are few.

Also, although there can be 95 different versions of the ABC form, we could go back and look, but I think I'm correct that there is at least a version of the ABC form that's required for purposes that is, in fact, available and people can get it. I mean maybe there are value added services provided by others. So this is not like what a shocking thing.

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

No. Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

... government supports the development of ICD-9-CM and ICD-10-CM and HCPCS and there are a lot of things that the U.S. government has done in this area, so I think that one of the ways to deal with this is to look at it in the broader context of what has been accepted as reasonable purview for the federal government to work in this area for—

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

Right. Before we get back to discussing alternatives that we might want to recommend there is one area of the scope of this recommendation that I wanted to explore a little bit. I'm so going to go off on a tangent here and that is the cross maps to RxNORM from the component taxonomies that are proprietary. So what are the feelings of folks on the call in terms of whether such cross maps should be in scope or out of scope for this kind of a licensing scheme?

Marjorie Greenberg – NCHS – Chief, C&PHDS

I mean generally I think the cross maps, we would like them to be available for people to use. Otherwise, we won't accomplish our goals. I don't know if there are any limitations from the agreement between IHTSDO and WHO that would be an issue here in the U.S. since we're members of IHTSDO and there is an agreement now between the two of them.

Betsy, would there be any issue there?

Betsy Humphreys – National Library of Medicine – Deputy Director

I don't think that there's going to be an issue.

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

Yes. I was actually drilling into the medication vocabularies ... and I was really trying to ask, I think, a slightly different question, which is many of the component parts of RxNORM also exist in, for example, First Data Bank or Medi-Span and others. It's those cross maps, given that both RxNORM and those proprietary ones are named in the regulation.

Clem McDonald – NLM

I think that's a really important point. If one twisted it, the regulation doesn't say you have to send RxNORM, so the places that have the proprietary will likely, if not already, have a mapping. So if they

sent it with RxNORM everything is fine. The only thing, if they don't, then systems like IHEs that would like to join them will have problems, because they won't have each of the mappings and they'd like to do something in common. So I think it's a good question.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

I'm confused. I thought that RxNORM was published with First Data Bank and other cross references as part of the RxNORM distribution.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Chris is absolutely correct. They are published. There are a couple of exceptions that I'd like to point out with regard to that. One of which is that Medi-Span and First Data Bank, at present, do not provide us with their branded name information. I understand that both of them intend, if they are not already doing so, to make their own cross maps. The other cross maps are all made by RxNORM and essentially the U.S. government has the intellectual property rights on the mappings that were done, but those mappings have not been done.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Right. So I was aware of those two. I thought there may be others as well, so those cross maps are actually products being sold by those—

Stuart Nelson – NLM – Head, Medical Subject Headings Section

As far as I know. I don't know how far along those products are, whether they actually have seen the market or not, but they are there.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

So, I mean going back to your question, Jamie, I don't understand what the problem is, because if you look at it, my understanding legally—and I'm not a lawyer, as everybody knows—is that you cannot copyright a code per se. So in the context of mapping it's perfectly legitimate for a public entity or any other entity to reference a code as long as they don't provide the context and other proprietary information associated with that code. In other words, you can't show the hierarchies, you can't show all of the other things that are part of that proprietary code system. But the code itself can be included in a map and that's exactly what RxNORM is doing. Stuart obviously is much more familiar with the completeness of that map, but I see it from an intellectual property perspective being a non-issue.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

That's not the experience we've had with one mapping that maybe I better not name. I think there is a question of derivative work if one uses one list and adds it to another list. I think there are intellectual properties, but I'm also not a lawyer.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

I'm not sure—

Stuart Nelson – NLM – Head, Medical Subject Headings Section

... actually been prevented from doing some things ... through that, but maybe we're naive.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics

My comment was I think the mapping itself is considered intellectual property. It's not necessarily the content at either end of the map. Chris, is that your understanding or—?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Well, but anybody is free to create that intellectual property and as long as you don't copy it or steal it, if you generate a map— Let's talk about drugs to keep it relatively neutral. If RxNORM were to create mappings to First Data Bank then RxNORM is free to publish that mapping even though it references First Data Bank codes. It just cannot include the hierarchy content layout and presentation, which is copyright within what First Data Bank presents. But the mapping itself— Maybe this is silly for us to chat about this

because, quite frankly, none of us know what we're talking about from a strictly legal perspective, but that's my understanding.

Clem McDonald – NLM

Well, I suggest we try to get that clarified, because it would make it easier if you're right, Chris. I've had the impression that lists are copyrighted. I think phone books and things like that are copyrighted and you can't just translate them into a different form without it being a derivative work.

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

Well, I'm glad I asked the question, because everyone else is exposing my ignorance and that's just actually perfect in this case.

Clem McDonald – NLM

I'm hoping—

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

Because I don't know answers to—

Clem McDonald – NLM

We can get answers, right? I mean I'm hoping Chris is right on, but—

M

Yes. I'm not sure you can get answers. Our discussions with attorneys about these issues have been frustratingly fruitless.

M

I like the alliteration.

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

Well, that was an interesting tangent and I think we're going to have to come back and somehow understand that better, perhaps, before we make a recommendation, because I think any recommendation that we make should have a scope attached to it and we're going to have to understand better what that scope really has to be.

So I'm wondering, Betsy, is this something that the National Library of Medicine can help us understand from that perspective, what the scope of the problem is?

Betsy Humphreys – National Library of Medicine – Deputy Director

We can try.

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

Okay. So I think then, getting back to the possible recommendation under discussion, I think what I was suggesting is we could recommend that at least two alternatives be considered, one of which is a straight, national license, making things free for use in the U.S. The other alternative is some variation on government administration or government collection of fees for national licenses. So I think that whether it's truly a fee for a national license or whether it's a fee for a nationally negotiated, per-user license is perhaps one thing we ought to discuss. I understand that it's certainly simpler to have either per-person or per-entity fee collection for an actual single national license.

At the same time, I think we did hear in the Standards Committee from the ONC folks some resistance or hesitancy about making the financial commitment to the actual national licensing, but I'm not convinced that there's the same degree of hesitancy about potentially negotiating fees. In other words, they may not want to make the budget commitment per se to a national license, but they may be willing to negotiate consistent fees for the country.

Betsy Humphreys – National Library of Medicine – Deputy Director

One of the things that is really critical in this is determining what the federal government and, in fact, specific agencies within the federal government have the legal authority to do. The notion of the federal government negotiating with one private party for fees that will then be applied to other private parties in the United States—

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

Sounds like a non-starter?

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, I think a piece of this is going to be ... various branches of the Office of the General Counsel to determine what, in fact, is actually legal to do and whether, in fact, to do some things that people might want to do, specific new authorities have to be given to particular federal agencies. I learned about this in terms of figuring out how we were going to deal with the SNOMED deal and also there were certain things, but the authorities vary by agency, so the issue is who might be authorized to do what for what group of constituents or stakeholders. This is extremely complex.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I was just sitting here thinking about the Federal Reserve Board. They are not a governmental agency. They're quasigovernmental and, as such, they have a great deal more freedom to do things than a federal agency does. Maybe we should be thinking about a quasigovernmental authority that would be responsible for these sorts of things.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. I don't necessarily disagree with that, but then you're talking about setting one up.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Yes and that's as fun as going through and getting the designated authority for a federal agency to do something.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that there is, of course, the notion that we would identify or could potentially identify—this was an idea that Clem brought up—specific groups of people for whom the subsidized or free access to things is particularly desirable or where it's particularly difficult and then say, "Well, is there a federal agency that actually has authority to set up a license that would cover them and pay for it?"

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

So Medicaid providers, as an example.

Betsy Humphreys – National Library of Medicine – Deputy Director

Another one would be public health authorities, so CDC might have authority to do that. So you look at it that way.

The other issue, it seems to me, is from the point of view of moving forward with meaningful use. Obviously, everyone would like it to be simple and everything would be available that they need and so forth, but could the Task Force or others within this thing look at this from the perspective of if we realize that we can't go from where we are today to nirvana of there is some arrangement so it's all free to everyone in the U.S. who has to need it. Are there particular pieces of this that are maybe the most problematic? Are there particular barriers to access to certain standards that are more troublesome than others and do you set up a look at the issue of what are the priorities and can we at least solve that one or something?

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

So this goes straight to the heart of the scope question and I don't know. I mean are there some of the requirements in the meaningful use regulation from both, a standards perspective and the incentives program that we would prioritize differently than others or would we say that anything that could enable an eligible professional or hospital to qualify for those incentives should be treated equally?

Betsy Humphreys – National Library of Medicine – Deputy Director

One could look at it the way and say if the licensing or the problem or the issue is at the vendor level or the product level and currently, under the current arrangements you don't have a requirement for everyone, who is going to use the product to have a license then that might be considered a lesser problem. Then, of course, the other issue is does essentially everyone who needs to use the thing already have a license to it for another reason, in which case they've already built that into their current use pattern for good or ill and it might not be regarded as a serious new problem.

I think the other issue is whether you look at it and say, "Well, let's not create more of these problems," as we develop mappings or ABC. I mean let's not add to the problem. Figure out a way that proactively, potentially, the government could work with that.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Well, to come back a little bit, Jamie, to sort of the question that was posed in the hearing about doing some kind of comparison or cost analysis, that seems hard to me. Maybe we need to head down there anyway, but I mean to do that properly I think what it would imply is that you would, in fact, to figure out the cost or the complexity of the government being a pass-through payer for the terminology you basically have to enumerate the terminologies and for each of those—

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

Right. You have to specify the exact solution and to whom it would apply.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Exactly.

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

Yes.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Which seems like a hard thing to do. I mean—

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

I don't disagree. I mean it certainly is easier for us, actually easier to make a recommendation—

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Does anybody want to do that besides Halamka? I mean it just doesn't seem like a viable solution to me. I would just as soon not recommend it.

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

Well, yes. I was going to say it's certainly easier to just recommend national licensing. I mean that's easier, but I think we need to try to figure out alternatives to that to the extent that we can.

Clem McDonald – NLM

The alternatives. Are there some other clearing house mechanisms? Are there commercial companies that do that kind of thing? Does anything exist as an example of things like that that one could suggest something about?

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

Well, does anybody use iTunes?

Clem McDonald – NLM

Yes.

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

Yes.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

Or the Copyright Clearinghouse?

Clem McDonald – NLM

Yes. Okay.

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

I mean certainly iTunes, as an example, does attach specific DRM technology to the downloads that are available there that don't attach to the kinds of artifacts that we're talking about here.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

But I don't think the analogy holds. I mean iTunes is a personal use and the DRM is essentially associated with a personal use device and that's not hard to scale. The problem we're confronting is systems upon systems using intertwined, interconnected information, information exchange where the intellectual property rights, if we're going to do it on a DRM basis, are going to have to transfer across systems or validate across systems. Again, I raise the issue of whether it's a physician or a hospital or a physician interfacing with multiple hospitals or worse, an HIE trying to interface with multiple organizations and trying to establish clarity over the intellectual property of the content that's being conveyed. I don't think the iTunes model scales to those kinds of cross system integrations.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I agree.

Clem McDonald – NLM

Could we propose a simplifying thing that the transmitters or the aggregators could be exempt from such fees, assuming that they got it from people who paid the fees?

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Suggest that all you want, but it will be determined in court whether that's true or not.

Clem McDonald – NLM

I won't suggest it.

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

I was going to say you get into horrible definitions over who is an aggregator.

Clem McDonald – NLM

Yes. Okay.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I would extend something that Betsy said too. I mean I'm becoming more polarized as I go here. If we do this sort of thing, essentially you're encouraging a marketplace for other people to create this kind of situation as a profit making venture. I just don't want to do anything to encourage that.

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

Right. Actually, Betsy asked, I think, a very interesting question, which is what could be done to avoid these kinds of problems in the future.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Well, there's an easy answer. I mean I've seen this. There's a lot of the newer code stuff is stimulated by the government. I mean brand new stuff. I don't want to name names, but some of the special survey instruments and the like. They all end up with copyright tangles and they're paid for usually by the government. I've complained about that to CMS, but whatever happens it doesn't seem to happen. So going forward it seems like we shouldn't get entangled with proprietary systems. They can be copyrighted, but then charge and require all of this bookkeeping.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

To quote foreign policy, “No entangling alliances.”

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. They’ll go forward. They’ll run a contract and the contracts say we want to develop this survey instrument for some particular purpose and they pay for it. They seat ownership to the developers and thereafter there are tangles. We’re our own worst enemy.

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

Well, I kind of like this conversation because it is recommending or it is pointing towards a recommendation for straight national licensing, but based on a lot of concrete reasoning. I think that despite the great hesitancy on the part that’s been expressed on the part of ONC to make federal commitments for these kinds of payments it does seem that there are many reasons discussed here that make that, in fact, the most cost effective way to go to make this program, the meaningful use program, a success. One alternative certainly is to have just that one recommendation with well laid out reasoning behind it.

Stuart Nelson – NLM – Head, Medical Subject Headings Section

I would be in favor of that.

Betsy Humphreys – National Library of Medicine – Deputy Director

The other issue, of course, is I think that that could be done in a compelling way.

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

Yes. I think different sorts of categories or different chapters in that reasoning could include examples of elsewhere in the health system or health sector where this approach is being taken in terms of government support. Many of the complexities, such as the physician relationships that Chris was talking about, some of the IP relationships of the particular artifacts and so it seems we could come up with several chapters of reasons for which this is the recommendation.

Now let me go back and sort of argue against that a little bit and say if we take a look at what else is supported by the government in the healthcare sector today, if we look at administrative transactions as an example, I don’t think X12 doesn’t make their standards free right, Don?

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

That’s correct.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that one of the things that we have to look at is whether the transaction that is involved is essentially a transaction from which—to me there is a different situation to requiring somebody to pay for the use of a transaction standard, the purpose of which is for them to collect money as opposed to because it essentially was originally implemented as a cheaper way of doing business and maybe it is or it isn’t, but in fact, every time the transaction is used the end purpose is that somebody is being billed and somebody is paying the bill. Therefore, for us to say, “Look, I have to pay bills and it costs me so much and if I do it electronically that reduces my cost of billing,” and somebody else says, “It reduces my cost of collecting,” then it seems to me that you have theoretically imposed—you’ve built an efficiency into what is a financial transaction.

I think that the issue that we have once we get out of that administrative area is that we have many, many transactions, which are for a variety of purposes and in many cases there is no transfer of funds associated with the transaction.

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

Well, but this actually, in my mind, is pointing to a different sort of chapter in this book, if you will. That is the overall systemic efficiency of using standardized vocabulary, as opposed to not.

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that what we all know is because we've been dealing with this forever in terms of electronic health records and many people more eloquent than I have spent time on this, is that we have built in to the whole use of electronic health records and the transfer of health information costs that are incurred at one place and benefits that are occurred somewhere else. Therefore, you're not dealing with someone who is doing something because it will allow them to process the payment or receive the payment more cheaply. You're dealing with other issues and then you are raising the barriers for the people who may not see any very immediate, tangible benefits.

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

I mean the benefits are to the patient and to the nation, but indirectly.

Betsy Humphreys – National Library of Medicine – Deputy Director

I mean it does seem that putting difficulties associated with gaining access to somebody's standards and paying for them is sort of like charging people to get onto the boat so that they can go down into the galley and row with oar. I don't know.

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

Here's my thinking based on this conversation. I think that a lot of different thoughts have been shared here in terms of different potential reasons for which a straight national license scheme making this IP free to use, at least for some users for some purposes, if not for all users, for all purposes in the U.S. is the right recommendation to make.

What I am thinking is that I'd like to ask our Task Force membership, specifically those on the call, to go and write up your thoughts. Send them to me and I can collect them and then I will put that out and have that be the basis for our next call.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Do you want to roll the two things together, Jamie? From my perspective it may be still useful to. I'm fully in favor of national licenses. Whether the national license that we charge a subscription fee per whatever, per download to recoup the cost, I think it's valuable to keep that separate so that you can essentially, fully in favor of national licensing, the question of whether it's paid for by the government or whether it's paid for, whether the government recoups the cost through a charge, I guess going back to what Stuart said, I mean if—

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

Well, that's essentially the Canadian model, which is that there is a national license, a portion of which is recovered through user fees. Now, in Canada it's a very low proportion and here I think we'd be talking about a much higher proportion, possibly 100%.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Right. It's just a question. I don't feel strongly, but it would seem if I had to give something up I would give up the fact that we needed to charge people. I would really resist the idea that we wouldn't do national licensing.

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

Well, what I would say is let's collect our thoughts and come back to that question, because I think that's a really good point. Maybe the recommendation that we're arriving at is one of national licensing and then the question of the analysis to be done is whether it's worth it to recover those costs or not and if so, how to do that, given the complexities of our health system and the potential uses of this intellectual property.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. Okay. I need to drop off. It sounds like maybe we're pretty close to done anyway.

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

Well, I think so. Stan, if you could write up thoughts on this and send it in and I'll ask others to do the same. My thinking is that we've had a very productive discussion here and I'd really like to get thoughts on paper from all of our participants here and then use that as fodder for continuing the discussion on our next scheduled call. Does that sound like an acceptable course or do folks want to continue pushing this further right now?

Betsy Humphreys – National Library of Medicine – Deputy Director

Your plan sounds good to me.

M

Yes. It sounds good, Jamie.

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

Okay. I will look for written comments from any of the Task Force members who can send them.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jamie, just a reminder, the next call is October 22nd, 2:00 to 4:00. We also needed to ask the public if they want to comment.

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

Yes. Do we have any public comments for this meeting?

Moderator

We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, operator. Thank you, Jamie.

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

Thank you very much. Thank you, everybody.