

**Surveillance Implementation Guide Power Team
Draft Transcript
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Presentation

Operator

All lines are bridged, Ms. Sparrow.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Good morning, everybody and welcome to the Standards Committee Surveillance Implementation Guide Team. This is a Federal Advisory Committee so there will be opportunity at the end of the call for the public to make comment, and just a reminder for members to please identify yourselves when speaking. Let me do a quick roll call. Chris Chute?

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

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Sharon Terry? Walter Suarez?

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Ken Mandel? He may be late. Marty LaVenture? Seth Foldy?

Seth Foldy – Wisconsin – State Health Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Rita Altamore?

Rita Altamore

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Kathleen Gallagher?

Kathleen Gallagher

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Taja Kathote? Warren Williams? ... Rajmani? Anna Orlova?

Anna Orlova

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anyone off? With that I'll turn it over to Chris Chute.

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

Thank you very much and thank you all for joining and the hard work you've done between meetings. As you see, I drafted an agenda which seemed to follow directly from our work items that we concluded at the end of our last meeting. It also parallels the brief presentation I made to the Standards Committee as an interim report this week. Are there any additions or concerns with the agenda? It's not that we can't change it later, but just as a framework? Hearing none, then let's move on to the first item, which is examining the material distinctions between 2.3.1 and 2.5.1. Rita, as I recall you and Prea were going to work on this. Now, Prea, of course was, I guess compromised by the Minnesota State Government shutdown and I presume prohibited from working on this. Rita, can you share with me what the status might be on that item?

Rita Altamore

Sure. We looked at a couple of different aspects of this. We looked at how ready public health was to accept the different standards and collected as much data as we could from a variety of sources. Seth has that. I don't know if we have it ready to present. But I think in general the bottom line was public health is much more ready to accept 2.3.1 than 2.5.1 but that we're working towards accepting 2.5.1 in every arena, syndromic immunization and ELR, every arena under meaningful use Stage 1. From the submitter side we talked about whether it was actually advantageous for submitters to be allowed to choose 2.5.1 or 2.3.1 and we've heard mixed messages. We clearly got a message from the Policy Committee to look at whether we could recommend a single standard. On the other hand, we've also heard from some folks that having the ability to make a choice is advantageous.

So we ended up making a decision to say that at this point we would like to not change anything in Stage 1, which should come as no surprise, and that we would like to be permissive about future stages as well, although we want to make sure that public health can accept both standards, with particular emphasis on 2.5.1. We are not recommending adding 2.3.1 to the reportable lab results criterion. We feel that both because the industry is moving towards 2.5.1 the recommendations that will come out of the S&I framework process are going to be 2.5.1 and public health is already building towards accepting 2.5.1, that there's no need to add 2.3.1 to reportable lab results. Seth, would you like to add anything to that?

Seth Foldy – Wisconsin – State Health Officer

Yes. First of all, we gathered what information we could about the current status. When it comes to electronic laboratory reporting a substantial minority of case reporting receiving systems have now built up to the capability of receiving 2.5.1 and the trend is strong and positive. So we think that although 2.3.1 receiving capability is more common today, we think that 2.5.1 is likely to catch up over the next few months.

We see a similar picture with immunization registries. There is strong and increasing adoption of 2.5.1, but still a minority of systems reported, if I remember right, towards the end of 2010 that they had full capability at that time. When it comes to syndromic surveillance, frankly, we're not getting our hands on very good data. But I know from my experience and discussions it's extremely likely that a lot of the data that flows between providers, EPs and public health agencies today is in the form of 2.3.1 ADT

messages, among other things. So that's our sense of where the public health side of the equation is, and of course as we learned on the last call the EHR industry has built to either standard rather than both standards or one standard, which means that our safest presumption is that were we to name a single standard and force rapid migration toward one or the other, we would likely be forcing a fair amount of work not just on the public health side, but at the vendor side, and for that reason it seemed appropriate, we had a small workgroup that had a good discussion last night that seemed reasonable to us to strongly encourage the capability of public health to continue to receive both message types. A couple of sub-issues included there are that, first of all, it's our understanding that agencies receiving 2.5.1 messages should be able, with fairly trivial work, also be able to receive 2.3.1.

And then there's another consideration out there, and I think it's later on our agenda, and that is that our group did see the concept of CDA public health reporting as looming large on the horizon, although not necessarily extremely close. In other words, we're thinking of it as something we would love to enable to be happening more, because there's very little capacity of public health to consume messages of that type today. So forcing a lot of migration and choice between different 2.x versions in advance of a subsequent probably fairly natural migration toward CDA didn't strike us as offering a great deal of advantage.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Chris, this is Walter. May I jump in?

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

Yes, you may, but let me put in a question first. I appreciate that we've jumped right to the answer, which is where we should go, but I was hoping for a little more elucidation on, frankly the differences between 2.3.1 and 2.5.1. I recall that was going to be one of our homework items so that we can get an understanding of are there substantial additional fields in 2.5.1 relevant to the public health messages that make this migration difficult for either the sender or the receiver? Or are they at least in the context of these three messages so similar that the fussing about the distinction is not material?

Rita Altamore

This is Rita Altamore. I can respond to that, Chris, at least partially, if you want me to.

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

Yes, please.

Rita Altamore

We'll take them separately. For ELR there's clearly a difference; 2.5.1 was created in part to respond to CLIA requirements in the United States and specifically addressed to the transmission of laboratory results. So 2.5.1 has a substantial advantage for ELR. It was what was recommended by HITSP for that reason. As I mentioned, it's what's going to come out of the S&I framework laboratory results initiative process, so I think the answer is really clear for ELR, that 2.5.1 has substantial advantages. For syndromic surveillance, the fact that we have a proposed guide that addresses both 2.3.1 and 2.5.1 probably gives everybody a hint that for the message types that are proposed for Stage 1, namely ... ADT messages, there really is no difference between the message structures in 2.3.1 and 2.5.1, at least not for the pieces of the message that we're using to report syndromic data. So the approach is the same regardless of the message type of the version chosen. I personally don't have enough depth of understanding of the differences between the immunization messages in 2.3.1 and 2.5.1 to speak meaningfully to that, and there may be others on the call who could.

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

That's extremely helpful, Rita. Walter or Anna, do either of you know the immunization distinctions?

Anna Orlova

This is Anna. I unfortunately can just speak on behalf of immunization registry distinction and I still believe that this committee needs to hear from the CDC immunization registry group, Mr. Warren Williams. It just would be very helpful to explain the differences for us. Unfortunately in such a short period of time we were not able to have him just talk at our meetings that we had.

Seth Foldy – Wisconsin – State Health Officer

Yes, we kind of ran into vacations.

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

That was Seth, right? Seth, from the CDC side we haven't had a formal consideration from the vaccination perspective of 2.5.1 and 2.3.1, is that –

Seth Foldy – Wisconsin – State Health Officer

No. And I don't want to speak for them but I will say that in their grant guidance to grantees they are explicitly encouraging migration toward 2.5.1, but not, as I understand it, with hard deadlines and targets. But I am aware that there is formal encouragement.

Jim Daniel

This is Jim Daniel. I think the main defenses for immunization with the 2.5.1 are in regard for fields required for the vaccine for children's program and also order management, more of an inventory management aspect of the message.

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

Right. What I do know is that they have used a variety of 2.5.1 fields to enable some of the bidirectional work of vaccine management, inventory management. What I don't know and have not had a chance to get an expert answer on, is whether such capability could not be built into 2.3.1. I do not have the answer and I don't know what the thinking is.

Rita Altamore

This is Rita Altamore. I just wanted to add that we also talked about the fact that for the purposes of meaningful use the use case is fairly narrow, at least for Stage 1 it's reporting immunizations to a registry, and again we weren't clear about whether all of the features that were provided in 2.5.1 were used for that specific narrow use case.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

This is Walter. I think besides some of the technical differences just in the general content of 2.5.1 messages versus 2.3.1 messages that apply to any applications, I think probably one of the more critical aspects is the implementation specification itself, implementation guide, and I know CDC and ARRA have released the 2.5.1 version of the implementation guide. And so I think whereas the standard itself on HL7 2.3.1 versus 2.5.1 presents some specific differences that apply into any application of the message standard itself, I think there's going to be differences in the implementation specification itself in the implementation guide. I'm trying to remember if the standards implementation specification and certification criteria named the implementation guides from CDC as the implementation specification for the standard, or they left it open. I'm not sure about that.

Jim Daniel

I'm pretty sure they named the implementation guide. This is Jim. That's my understanding.

Anna Orlova

This is also because this is the only implementation guide for 2.5.1 for immunization.

Rita Altamore

Correct.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

So my –

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

Wait, let me ask, does that mean there's no implementation guide for 2.3.1 for vaccination?

Rita Altamore

No, this is Rita. There's also a 2.3.1 guide, both of which are published on the CDC Web site and through ARRA.

Anna Orlova

What I'd like to say, Chris, is that for 2.5.1 there's only the one implementation guide developed with the support from CDC, Warren Williams' group, just available to implement 2.5.1 standards. We found different implementation guides for other domains for the same standards, but this one fortunately had just one implementation guide.

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

Okay. I'm hearing a fairly strong consensus that for electronic laboratory reporting there are material differences between 2.3.1 and 2.5.1 sufficient to continue with the recommendation of the single standard for electronic laboratory reporting due to CLIA requirements and other fields and parameters that are important in that space.

Seth Foldy – Wisconsin – State Health Officer

This is Seth Foldy. I'm not sure if CLIA requirements would have informed our thinking there

Rita Altamore

No. This is Rita Altamore. I only meant to say that CLIA requirements informed the creation by HL7 of version 2.5.1. The .1 addition was specifically in response to those requirements, adding fields to the OBX segment, sorry to get geeky, in order to contain information about, for example, performing labs that were felt to be important and that those also offer substantial advantages for public health.

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

Okay. And I get that that's the key message: "substantial advantages to public health." I don't hear a lot of dissent on that.

M

I will say there are those who say that the advantages to public health may not be massive. In other words, many of us were wondering about a reversion to 2.3.1 simply to acknowledge that a great deal of electronic laboratory reporting was currently going on in that space. But another consideration that our small group asked is, is it appropriate now to reopen the issue across all of the three industries and force the EHR industry now into adding an additional standard, 2.3.1, to 2.5.1 and it seemed that the effort of doing so would have little overall benefit, just to be clear here.

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

I accept that. There is a consensus that retaining the 2.5.1 for electronic lab reporting and not introducing 2.3.1 is a path forward in that particular space. For syndromic surveillance I heard very clearly that at least for the ADT messages that are being used, the differences in segments and content between 2.3.1 and 2.5.1 are nil. I heard that for immunization there are some advantages to order management and inventory management and something about vaccinations for children, I wasn't quite sure how that figured in, that might favor 2.5.1. But the reality is the community is not uniformly able to receive 2.5.1 messages. We're still dealing with a significant legacy of 2.3.1 capacity, so I heard some indecision on that one.

My sense, though, is that, I'm just thinking of this from an informatics perspective and a consistency perspective, if we're using 2.5.1 for electronic laboratory reporting, so at least public health is able to accept a 2.5.1 message in that space, are they different shops in public health centers that would accept syndromic surveillance and/or vaccination data? I'm going to ask the totally naïve question here, if they can accept 2.5.1 for lab why can't they accept 2.5.1 for other public health reporting?

M

There's nothing naïve about the question. The answer is yes. These are sometimes very different shops. I think we have strong interest in public health towards migrating them towards common receiving and routing, busing, and stuff like that, but that's not the state of the nation today.

Anna Orlova

I would like to add to this, Chris, is that when we're talking about HL7 messaging, we're talking about point-to-point connections built separately to immunization registry and then again to labs and then again to syndromic surveillance systems, basically for each health department, and right now I'm talking about three connections to receive this data multiplied by of course two standards that could be just six, but I just would like to bring our attention to the load that we're imposing on the providers sending this even 2.5 messages that may be more in favor to health reports, to laboratories, in these point-to-point communications. Today we ... that most of ... systems could send information in 2.3 asking them to upgrade their systems and also to send information in 2.5 could be a huge burden, specifically for ambulatory providers. We discussed some issues about compatibility across 2.3 and 2.5 and maybe the need to put all this burden of completing one message into another in the HIE space, or have health departments build these capabilities, to receive those transactions in one place and then distribute them across public health programs.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

This is Walter, a couple of comments on these points, and bringing the experience of the other world, of HIPAA, the administrative ... world, there is that reality in the market that of course entities and their internal systems are not necessarily expected to natively generate specific types of standards. But they can certainly work with entity vendors that will allow them to translate, to transfer, to map, to step up or step down, however we want to call it, whatever transaction that comes out of the system from the entity in whatever format and then put it into the standard message format that is expected at the other end of the transaction. So in the administrative world entities generate a health care claim using whatever standard and put it out to their processing systems, their clearinghouses, their business associates that perform that function of translating that into the X12 A37 standard, for that matter.

Now in the clinical messaging realm that probably will be a little more complex, and generally speaking the systems and the electronic health record systems are expected to be able to generate natively some of these messages. But in reality I think there is the possibility that entities or services can be provided to step up a version or two, move it into a standard version, which certainly in the realm of electronic health record system vendors will simplify things, because they will be coding for a specific version, say HL7 2.5.1. Or, for example, at the other end, public health agencies will be able to have an interface, a service provider that will take the message on, say, 2.5.1 and step it down or transfer it into whatever format the public health agency might be able to receive it. It could be simple, flat file messaging. So that's one consideration that in my mind pushes for convergence to a single standard.

The other comment I wanted to make is that since we've been talking about how things are evolving in the next few months or several months, whereas with respect to Stage 2 we're really talking about three years down the road starting in 2014, if the meaningful use Stage 2 is delayed, a one year delay is accepted, and so to what extent, we're thinking more about the immediate situation and a near future situation versus a more three year down the road situation where by that time not only the vast majority will be talking 2.5.1, they might be moving to CDA and moving to some next level standard. So I think it's important to keep that in perspective and think whether three years down the road the discussion will still be that the vast majority of entities are still in 2.3.1.

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics

Chris, this is Marty LaVenture.

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

Thanks for joining us, Marty. Go ahead.

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics

I'm sorry I was a little bit late. If I may just add a comment related to the question of if 2.5 is in, say, a state health department the ability to in one program for, say, laboratory reporting, how might that translate. And I think the descriptions we've been hearing is, I guess I would describe it as there's a bit of variation in how that may be architected for whether it is directed to a program or directed through a central services capability. But the fact that it is in an organization and receiving a 2.5 message given the type of training organization coordination through the IT folks in addition with the program folks is a huge step. Making that service available to other programs is much easier than starting from scratch.

So that, in my mind, encourages the recommendation towards the acceptance of 2.5 and working towards that common approach given it is important for laboratory reporting and the other programs, if necessary, can help define an architecture for that organization which will support the 2.5 messages in a number of different programs. Obviously we're talking three at the moment, but more broadly a variety of other programs are looking at providing that capability to receive messages and obviously then transmit those messages back to agencies and developing that capability. This would seem to set forth a very important discussion and implementation to support that capability and it's really a platform for launching I think a broad messaging capability here and then eventually with the CDA into the future. So I think it's an important step.

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

Let me be clear, if I understand you correctly, Marty, you and Walter are both advocating that we consider a 2.5.1 recommendation for all three messages based on the premise that it's not going to kick in until 2014. I heard Walter say, and Seth say, that we're months away from having meaningful migration towards that. And, Marty, your key point was that it would provide a common framework for public health messaging generally among recipients and senders and having to deal with multiple platforms might actually add a layer of confusion. I didn't hear you say that, but I'm inferring that. Am I misinterpreting you?

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics

No, that is a wonderful inference.

Anna Orlova

This is Anna Orlova. I would like to express my reservation about moving into this particular direction, for the following reason. We today see how long it takes to develop implementation guides for laboratory reporting as well as for immunization. It took years to develop this 2.5 implementation guide. Today I'm not sure that other programs strongly continue to see their ... is this incremental implementation of messages. They see a lot of benefits of jumping from whatever they are and most of them do not have standards based connections. They just have proprietary assistance. When jumping in the future of interoperability, which is structured documented changes, forcing them right now to jump from nothing into 2.5 and then 2.6, 2.7, 2.8, and whatever ... in the past that that would just require effort that might not in the long run be effective.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

This is Walter again. Anna, but wouldn't you agree that if people are going to be jumping from zero to 2.3.1 or jumping from zero to 2.5.1 would be the same effort, the same effort in the sense of well, this is a

big jump. So rather than jumping to 2.3.1 from zero and then from 2.3.1 to 2.5.1 in the next one, I think people can, if they are really at zero they can be moving to the 2.5.1 standard. Now, one suggestion perhaps to consider is that in the recommendations there could be a sunseting that date for up until when 2.3.1 will continue to be accepted. In other words, for example, right now it's both of them until Stage 2 kicks in. Well, Stage 2 kicks in in 2014 if they, again, accept one of the extensions. So maybe the sunseting of 2.3.1 could be maintained through, let's say, 2014, but at the end of 2014 2.3.1 will be sunsetted.

Seth Foldy – Wisconsin – State Health Officer

... can I ask a question? This is Seth Foldy. Our group, which for better or worse is largely inside the public health realm, although it includes a number of people who interact a great deal with vendors and providers, we are hearing two things. We're hearing, first of all, a quick point that you made, my concern is not the people going from zero to a new standard. My concern is how many people might we be forcing to move 2.3.1 to 2.5.1 and what's the benefit. It raises a question for us and we've heard two answers. We heard you say, oh, it's a lot easier for providers and vendors to settle on a given standard even if they're already using a different standard today. We've also heard people say if they're using a given standard today it's a lot of work to get them to adopt the new standard. I can't reconcile the two.

Anna Orlova

This is exactly the point that I have in my mind thinking about this transition, because if I would be the head over a particular program I would not consider jumping into incremental implementation of messages. But I'd rather look around to see what the meaningful use said about standards that are accepted by clinical communities, and this is clearly ... medical summaries which might contain a lot of information that my program could have already for what needs to be reported. If I have proprietary systems, which is the majority, I would rather think what are the needs to be implemented three years from now, what is the direction, what are the trends. The trends ... especially with the programs in the maternal child health, ... registration, newborn screening, cancer reporting is in ...

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

So from the perspective of a submitter of the data, speaking as a provider here, and to address some of those points about what's the benefit of going from not zero to "x" but from 2.3.1 to 2.5.1, I can argue that it is very expensive for me to maintain 2.3.1 for some things, 2.5.1 for other things, CDA for other things, and whatever other things are coming down the pipe. Converging into a single standard, even if it's from 3.2.1, or even from 2.2.1, creates significant simplification and efficiency and certainly savings, whereas today, yes, the reality is we have to support 2.3.1, 2.5.1, CDA, and then we're looking at 2.8x, into the future converging to a common standard has to be the goal, in my view.

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

This is Chris. Let me just add that, Walter, your notion that we might consider sunseting 2.3.1 at the end of 2014 is intriguing, but sadly, as I understand our latitude, we do not have the option of that micro specification. We either make a Phase 2 recommendation with a signaling of what Phase 3 might be, or we don't. That's the latitude of our capacity.

It was also raised, I think, Anna, by you that well, gosh if we go down the 2.5.1 does that mean we're going to ask them later to do a 2.6 or 2.7 or 2.8 and so on, and I don't think so. I've not heard that on the agenda. I think it's really a question of consolidating existing HL7 standards and then considering, as you pointed out, a potential future alternative to these version 3 CDA alternatives. But I don't think that's going to be within the scope of Phase 2 for sure. The really fundamental question is whether we signal that in a Phase 3 or simply say that that could follow on at some future time.

Let's defer the CDA discussion for the moment. I really want to get to closure on our Phase 2 recommendation, because I think it's safe to say that it will not include CDA as a Phase 2 element. I'm hearing actually strong argument in favor of consolidation on to a single standard. I'm hearing that there are compelling reasons in electronic lab reporting and maybe some good reasons in vaccination, if not for the immediate meaningful use then in terms of general other issues that are of interest to public health and providers, such as inventory management and related activities for vaccination. Then it's hard for me as a provider, and I'll wear the same hat Walter was wearing, that if I'm going to use 2.5.1 for all those other things, why in the world would I want to maintain a 2.3 space or engine for syndromic surveillance when I've heard that the distinction from a messaging generation and content perspective between 2.3.1 and 2.5.1 for syndromic surveillance is negligible, that the ADT messages are similar. So I'm assuming from that that my cost of implementation, at least for syndromic surveillance, to migrate from 3.1 to 5.1 will be correspondingly modest.

Seth Foldy – Wisconsin – State Health Officer

Chris, Seth Foldy. No one's being forced to stay at 2.3.1, is the way I view the world, and especially if we're encouraging public health to develop the capability to be omnivores, to accept either. So I think perhaps the biggest question we have, and we were not sure what the answer was, is adopting a single standard will create some disruption in the public health space, and it was our understanding that it would also create essentially considerable disruption in the healthcare space. And what I'm hearing strongly from Walter and you is that the maintenance of two standards is actually as onerous as shifting. And I just want to make sure that we have the voices on the phone, because what I don't hear is, I don't hear a big cross-section of the industry and I just want to be a little cautious before we were to make a decision that would cause an awful lot of healthcare to have to change what it's doing today when the benefit for public health would be very modest

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

This is Walter. I think it's important to clarify, if I read it, it is indeed forcing, particularly as we move to Stage 2, it is going to force entities, providers to support the type of standard that a public health agency is capable of receiving because Stage 2 moves immunization, for example, or lab reporting, or syndromic surveillance to core and establishes that providers and eligible professionals and eligible hospitals, will be required to test and then to submit the data using basically the standard, so using one of the two standards, and if the entity that is receiving that message is capable of receiving any one of the two standards the expectation is that the providers who needed that data will have to comply with the submission of that message in the standard in which the entity that receives it is able to receive it. In fact, the reality is that we would be probably forced to support in some jurisdictions submitting 2.3.1 for the same message and in other jurisdictions the public health agency is already capable of receiving 2.5.1.

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

Let me reiterate that, and I agree with Walter completely. The de facto conclusion is that an "or" statement in meaningful use effectively translates into an "and" statement for providers. There's just no way around that. In fact it would force us to maintain two standards going forward if there's an "or" statement in the requirement.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Chris, one other clarification point, I guess, on the potential recommendation. One caveat that we should make is that the assumption is that the one year delay would be adopted. If CMS decides, no, we're not going to do a one year delay and the recommendation, for example, is to converge to a single standard, that would probably not be feasible because that's a year and a half down the road. One caveat would be to make sure that in our recommendation, whatever it is, we include the notion that, we assume that the one year delay will be adopted.

The other caveat I wanted to make, Chris, you mentioned that we don't have the latitude of recommending some procedural steps in terms of deprecating a particular standard in the pathway. I would probably disagree with that. I think we probably have the ability to recommend that for Stage 2 the standard to be adopted be "x" and in Stage 1 when there's two standards we recommend that during Stage 2 the alternative standard be phased out at "x" date. I think we do have, in my understanding, the ability to present some recommendations about that, in my reading of it.

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

My interpretation, Walter, is that if we recommend in Phase 2 the standard be "x" then the standard is "x." The fact that there's an alternative standard that may have been existing is immaterial at that point, because to meet eligibility you have to ... "x," so phasing out that first standard is a fait accompli by specifying in Phase 2 that this is the standard that now is appropriate for meaningful use.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Yes, it's probably it's all in the wording. Let's see if we say Stage 2 and we don't know how long Stage 2 is, maybe it's 2014 and 2015, we can recommend that for the first year of Stage 2 the standard be still the 2 and for the second year of Stage 2, or starting in 2015, let's say, the standard be only one, something like that, that in effect delays for one more year.

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

But what you're doing, Walter, is you're introducing a sub-phase. You're saying that there's going to be a Phase 2a and a Phase 2b, and therefore certification would have to gear up and accommodate the notion of a Phase 2a and Phase 2b, and I don't think we have that latitude –

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Good point. So maybe we can –

Anna Orlova

Chris, I'd like to get some clarification from you. When we're talking about selecting ... standards versus ... are we talking about this three domains that are currently selected for meaningful use, or are we talking about future domains that will be added and then will be impacted by this decision? I really ... talking about these three domains, laboratory reporting –

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Actually, it's two domains.

Anna Orlova

... immunization and syndromic surveillance. So let it be whatever is just discussed here, but –

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

It's two domains, Anna. It's only immunizations and syndromic surveillance, because the lab reporting only has one standard.

Anna Orlova

No, the issue I see here is if we're talking on behalf of all public health then opinions of these other domains have to be taken into account. We can ideally make decisions as it relates to these three particular domains.

Seth Foldy – Wisconsin – State Health Officer

It's Seth Foldy. I believe the answer to Anna's question is we are in fact only talking about syndromic surveillance immunization reporting and electronic laboratory reporting, not the future of public health reporting writ large.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

And for electronic reporting the regulation already is only one standard, so we're not even going to have to address lab reporting in that they're already one standard.

Jim Daniel

This is Jim. I think what Anna is saying is very important to consider, and that is there's been talk about adding things like case reporting, which is very different than electronic lab reporting, and should we at least think about that as we think about the standards. Because I think we'll get to the point where in a few years when we start thinking about adding case reporting, 3.0 is going to be the obvious thing to use and are we going to be in exactly the same situation where now we're facing two standards but it's 2.5.1 and 3.0.

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

This is Chris. I obviously don't know the answer to that, but I daresay that keeping 3.1 in the mix doesn't add any benefit to this question. If anything, it continues the inertia and the multiple proliferation of systems. We, I think, agree that having two standards is bad, but I'd rather have two than three, so if we get down to Phase 3 the last thing in the world I think we'd want to impose on the community is 2.3.1, 2.5.1 and maybe CDA. I think what we're trying to do is, all right, let's streamline what we can for reasonable reasons for the time being and I guess we've segued our way into the CDA discussion, which is going to be part of our, I guess, deliberation. I think what we might do is signal that consideration of CDA for Phase 3 as a possibility is something that we could entertain, because I think we all agree that the flexibility for public health reporting, be it cancer or case reporter or maternal and child, or many of the use cases that we're all familiar with could be handled both by providers and potentially by recipients much more cleanly in a CDA context, and by the way, I think we should call it CDA rather than version 3.0.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Yes.

Rita Altamore

Agreed.

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

Then it might otherwise be in a 2.5.1, but I am trying to get closure before we go into the CDA discussion on what our recommendation for Phase 2 would be, since I think it's clear it will not include CDA unless, again, we're signaling something as a Phase 3 possibility. But I'm hearing that there seems to be compelling reasons to consider a single standard, that 2.5.1 is obviously the preferred alternative, that it may require people being able to, for the two messages we're talking about, retool for syndromic surveillance, that retooling may not be very difficult. For vaccination it may add more fields and therefore be slightly more difficult, that there are alternative ways to manage this through translation engines and through other mechanisms that Marty LaVenture and others had raised. But I am hearing, consistent with what the Policy Committee had requested, that the notion of a single public health reporting standard for vaccination and syndromic surveillance may be appropriate given the caveat that Walter raised that there's a one year delay in the implementation of Phase 2.

Seth Foldy – Wisconsin – State Health Officer

Seth Foldy, just to add, unless there's voices against, that we say explicitly that this recommendation is being made in our understanding that this serves providers and vendors their need for simplification, that it's not a request from the public health world that everybody change what they're doing, but that we make a recommendation in the understanding that this actually serves the interests of the larger community that will be making the change.

Anna Orlova

What this says, Seth, I'm not sure we can state it right now.

Seth Foldy – Wisconsin – State Health Officer

In other words, what we're saying is the committee made the recommendation in that belief that –

Anna Orlova

I'm saying maybe we need to expand the discussion for our ... this discussion for further deliberations to hear, for example, from the clinical community.

Seth Foldy – Wisconsin – State Health Officer

That's the reason I actually wanted to insert it in the recommendations because if we hear that the clinical community doesn't agree with our assumption it provides grounds for reconsideration. Its answer I don't have at hand.

Jim Daniel

I think the one thing that we would be hearing is those entities that have been sending 2.3.1s are going to end up being charged a lot of money by the vendors to convert to 2.5.1. Because the vendors are going to know that they've got them under their thumb. They're not going to want to rip and replace and go through systems that already does 2.5.1 and the vendors are going to be able to charge whatever they want to do that upgrade.

Seth Foldy – Wisconsin – State Health Officer

But they're doing 2.5.1 for lab anyhow.

Jim Daniel

It doesn't matter.

M

Our understanding is that the –

Jim Daniel

And for eligible providers they're not doing 2.5.1 for labs.

Seth Foldy – Wisconsin – State Health Officer

Again, hopefully I'm not going overboard here, but our subcommittee came to the recognition that the big problems affecting people out there are vocabulary, the quality of implementation guides, and the quality of implementation of implementation guides, and not necessarily the standard. But changing the standard would force of course many of those other issues into play and the creation of new interfaces. So that's why we would offer that caution. We're not sure. I cannot assess how much the juice is worth squeeze, or vice versa.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

The question is for whom, because I think we hear on this call the perspective of two providers. I don't think the test is on the clinician side. I think the test is on the public health side, whether there is some additional benefits or there is some additional costs and challenges to converge to a single standard.

Anna Orlova

You are totally correct, Walter. This is a great challenge, because of no funding available to upgrade public health systems under meaningful use, we all know that. So we can make recommendations but it will fall back on agencies to find resources to execute those recommendations.

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics

But that's always been the case. This is Marty. CDC has already made recommendations to the immunization registries for moving the 2.5.1 and both materials and the guides that are developed, and that's a movement that's clearly moving forward and it's an issue of how fast can the followers learn from

the pioneers' challenges and lessons to be successful more quickly. We know from the laboratory described earlier that that clearly has some value as well, that there are ... components to 2.5.1. It's really in the syndromic and looking to the future, that, yes, there are challenges that we can, I look at this as not challenges but as focus from the public health community. We're really going to focus our efforts around 2.5 and the guys that go with that as the HL7 message to really implement it successfully, consistently, through our training, through the sharing of the information, and the resources that we do have, being able to leverage it towards that single goal. And I think that will have a strong value and impact towards success within the public health community. There's always going to be those that are, for a variety of reasons, that are going to be further behind, and those that already have implemented 2.5 and we can learn from as quickly as we can.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Chris, this is Walter. We do have to address a fourth item, like we said, so laboratory, it's clear we're not going to make recommendations to add now 2.3.1. It's already established as 2.5.1 in the regulation, so that's fine. For syndromic surveillance and for the immunization registries, whatever we recommend converging towards 2.5.1 there is a fourth one, and that is in the recommendations from the Policy Committee for meaningful use Stage 2 they recommended that CMS consider adding public health case reporting starting with cancer reporting, and so we might want to make a statement about if CMS were to adopt the recommendation of including a meaningful use metric for public health case reporting, then we recommend that the standard be "x." We do need to include that as a provision.

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

Before we go there, and it sounds like the call has a rough consensus that the committee recommends eliminating 2.3.1 for the two surveillance items of syndromic surveillance and immunization and that we are doing so on the basis of our understanding that this will make life easier for hospitals and providers. Is that acceptable to the group?

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

I don't necessarily agree with that, acceptable only to –

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

I didn't say "acceptable." I said the main impetus.

M

Well, I also heard Marty LaVenture say that it would enable public health to have a focus.

Walter Suarez – Kaiser Permanente – Director, Health IT Strategy

Yes.

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

Seth, you yourself were saying that it would be desirable to have a common bus, and we all acknowledged that public health isn't engineered that way at present most places. But this would be potentially an enabling or focusing type of activity because right now it's kind of hard to think about a bus if you've got multiple standards.

Seth Foldy – Wisconsin – State Health Officer

Again, one of the reasons I bring this up is because public health is considering focusing on CDA, which will also take considerable effort. And with constrained resources we try and do everything, but sooner or later we prioritize.

Anna Orlova

I agree with Seth on that. And Marty, sorry but I respectfully have a different opinion on the situation as you described it, because I believe right now we have two sides of the immunization story. One that is funded to go into CDA that would be, I don't know, and they will be, as you called them, "followers" but maybe those followers wouldn't take this bus. They may choose to do standards that would be recommended for Stage 3 and Stage 4.

M

I'm willing to accept the recommendation the way I stated it. I'm a little uncertain that I would want to go back to the public health community and say we did this for you, and I'm a little uncertain that I would like the entire provider community to point at this new scope of work and say public health made us do this. I'm thinking if the committee is saying it's important that it be done to facilitate messaging from providers, that we say that.

Seth Foldy – Wisconsin – State Health Officer

I think we can say it articulating the advantages and reasoning, and they include the ones that you're saying. But I would also want to add Marty's insights that it does provide a focus, at least in the short term, for Phase 2. Now we can talk about CDA, and I'm happy to move on to that topic, but let me then just declare closure on this point with the rough consensus, as you've characterized it, Seth, and we'll include the reasoning and arguments that we've articulated on this call, including consistency and simplification for providers, yes, that's certainly true, and we did make that point. But I also think potentially enabling a focus for public health implementation would be advantageous.

Jim Daniel

This is Jim. I just want to say this one more time because I think we can end up with an unintended consequence of providers who have been attesting for a couple of years at that point with a 2.3.1 message, having to pay their vendors to upgrade them to 2.5.1 could end up being an issue. I've already heard stories in the field of providers who didn't want to pay the interface cost to develop an interface registry saying they're not going to get immunizations anymore, they'd rather take the exemption because they don't want to pay that cost, and I just want us to carefully think about are we going to be putting extra costs on providers who have been playing along and submitting immunizations per meaningful use standards ... 3.1.

Seth Foldy – Wisconsin – State Health Officer

Can we agree to create a list of potential pros and cons so that these issues can be out there for people to exam and comment and hopefully inform us as to where the truth lies.

Jim Daniel

I totally agree that a single standard is best, but I think we can have some unintended consequences of the providers being forced to pay for new interfaces and they're going to be forced to overpay because they're not going to have a choice.

Rita Altamore

This is Rita Altamore. It sounds like we've got two groups of providers, one of which will incur costs if we maintain two standards, and one of which will incur costs if we go to a single standard.

Seth Foldy – Wisconsin – State Health Officer

Right. I think there's stuff that we don't know. The best we can do in our letter is to state our recommendations the assumptions underlying the recommendations and our perception of pros and cons. Does that sound friendly to everyone so that we can get something out there?

Anna Orlova

I would agree with that. A pros and cons assessment I think would be very healthy at this point to see the direction we're going.

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

Okay, now that we've achieved this – thank you, Seth, that's a good summary and I sign on – let's move on to the second bit, which is what, if anything, are we going to do with the CDA suggestion? I guess our options are to signal to ONC that we might want to introduce this for more broad-based public health reporting and maybe as an alternative in Phase 3. It's beyond our scope to talk about whether there's life after Phase 3. It's clearly something that we could entertain at a future time in the context of the Standards Committee moving on, since I think it's inevitable that there will be maintenance issues

associated with notions of meaningful use. Even if there aren't formal phasing and incentives, there will be penalties for not complying, at least from a CMS perspective, and I think it's inevitable that we will have maintenance phases and update phases of these criteria moving forward, perhaps on a biannual basis forever. But that being said, I've heard compelling arguments in favor of thinking about a CDA option, it seems to be quite favorable for case reporting and other kinds of modalities. I must say intuitively it makes sense to me. Is there agreement that we could –

Seth Foldy – Wisconsin – State Health Officer

This is Seth Foldy. I'm going to take just a couple of minutes to give a historical understanding of how the issue popped up at the Policy Committee.

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

Okay.

Seth Foldy – Wisconsin – State Health Officer

There is hope in the public health community that a CDA standard could, with selectable templates, could accomplish many different types of public health reporting in a fashion that would be simpler ultimately for both EHRs and public health systems. But we know that getting to that implementation guide is going to be hard work by a lot of people to get it right. So there was a vision of signaling this for Stage 3. Work has been done in this area. There are public health programs that are actually going to be testing and balloting versions of CDA reporting in the coming 12 months, such as the cancer registries program. We're not originally talking about Stage 2, but there was very strong interest at the Policy Committee to say if you're signaling for Stage 3, what are you going to do in Stage 2 to show that this is a reasonable thing to do. When you start seeing the language about the cancer registry, that was put forward as one of the use cases that was considered potentially and probably likely ready for adoption in Stage 2 and would allow us to move down this road with subsequent rules for Stage 3. Thus the history of how it developed.

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

Thank you, Seth. Does that change the suggestion or recommendation that we consider, as you suggested, signaling CDA might be considered for some Phase 3 use cases, such as cancer reporting and potentially case reporting.

Seth Foldy – Wisconsin – State Health Officer

The only thing that that leaves unanswered is actually the Policy Committee suggested that CMS consider cancer reporting as a use case in Stage 2, if I remember their recommendation correctly.

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

Yes, and maybe we could weigh in on that and say that, frankly, the adoption of CDA in Phase 2, both for providers and for, well certainly for recipients it may be too challenging and it may be premature to include that, specifically cancer reporting, as a Phase 2 requirement because of the implications of the underpinning standard support and engineering.

Rita Altamore

This is Rita Altamore. Cancer's a special case because of the really truly excellent work they've done in creating nationally harmonized standards for their needs. And so I actually think that based on the tools that the cancer registry is receiving from CDC that they are ready, or will be ready by Phase 2 to receive CDA. But they're a very special case within public health. Clearly very few other public health entities are ready to receive CDA. On the other hand, I absolutely totally support what you originally said, Chris, which is we need to make the signal and we need to be ready because that, without question in my mind is the way we're going to go.

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics

I would agree with that. This is Marty.

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

Okay, so I'm not hearing any dissent. That was an interesting bit of insight, Rita, on the fact that cancer registries, and for that matter public health cancer recipients are perhaps ready to receive CDA today. That's a newsflash to me. Should we not make any statement then, one way or the other about cancer reporting, as I was suggesting?

Rita Altamore

This is Rita again. Let's double check with the cancer registry folks and NAACCR, their organization, to make sure that I haven't misstated. But it is my understanding that they are actually eager to proceed down this path on those Stage 2 timelines.

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

Okay, now, Judy, give me some indication of what our time constraints are. Obviously the Standards Committee will have a telephone meeting in August. Is that our drop dead date for delivery of a potential letter for consideration by the Standards Committee?

Judy Sparrow – Office of the National Coordinator – Executive Director

Actually, I think that Doug has been talking about September for any of the drop dead dates, so you might be able to stretch it out until September, if I recall correctly. The summer camp reporting out was the September Standards Committee meeting.

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

Okay, that's actually quite helpful. We can perhaps create a draft of that letter in the next several weeks and maybe schedule another call to consider that draft among us and debate the details, because I think we've got the big pieces largely agreed upon. There's one other agenda item, and Seth you tell me if we need to discuss it in any degree of specifics, and that is the syndromic surveillance implementation guide. I know you and others were working on it. Is that a yes, of course kind of thing?

Seth Foldy – Wisconsin – State Health Officer

I'm not sure anything is "yes, of course" in this world. If I'm not mistaken I've sent the draft for public comment to the committee so that they could assess its readiness for implementation. That draft had a public comment period with rural register publicity, and they received 44 comments in the public record and the HL7 committee also has looked it over and submitted comments, and most of these are modest issues, we'd like you to add a little of this, we'd like you to specify this more concretely to facilitate its implementation. I will point out that the draft actually is written as 2.5.1 but back compatible to 2.3.1. So we've not received a lot of comment that has challenged the suitability of the implementation guide, however, we did not receive, and I believe we tried to get it, we have not received a lot of comment from the EHR industry, so it might be worth one last peek to make sure that people are comfortable.

M

....

Seth Foldy – Wisconsin – State Health Officer

... as I understand it.

M

And that's only the implementation guide for hospital based syndromic surveillance?

Seth Foldy – Wisconsin – State Health Officer

Yes, thank you, ... for bringing that up. There is no implementation guide for ambulatory for so-called eligible providers, but there is a process and that process is expected to take a number of months, I think we're approximating about a year, with careful use case definitions and then message definition and then a messaging guide. That is not available for implementation in the coming calendar year.

M

Okay.

Seth Foldy – Wisconsin – State Health Officer

I suppose one question for the committee is, did anyone actually look at this guide and have anything that they thought was a big issue?

M

I was actually at a meeting with Doug Fridsma where he did have some issues with it. I think he was concerned about the number of fields that are –

M

....

M

... that could be left blank.

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

Do you mean that would be allowed to be left blank?

M

Yes, and I think he was encouraging us to think more about making a smaller number of fields required and more fields optional to really go back and think about what are the eight to twelve elements that you really have to have, making those required and the rest optional. He felt that would be a better approach to that particular implementation guide, and Taja was at that meeting and we all agreed that we would all go do our homework and come up with a recommendation for that.

Kathleen Gallagher

This is Kathy Gallagher. I was at that same meeting with Jim and Taja and Doug and so we did agree that we would try to engage some folks to see if that was a viable option, if Doug's suggestion was a viable option.

M

Jim, Taja's here, and I've been in discussion with IGS this last few days and we're going to start working on that next.

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

Then I guess an ideal might be to have such changes represented in some final form in time for our September Standards Committee meeting, is that your understanding?

M

Yes, that would be my understanding. We obviously can't send a letter recommending a document if the document isn't finished, so yes is the answer.

Rita Altamore

This is Rita Altamore. If we're going to make substantive changes in the document then presumably we're going to have to put it out for public comment again.

M

It sounds like there were substantive changes.

Rita Altamore

Going from required but maybe empty to optional would be in my perspective considered a substantive change, especially if some of those elements are perceived as important by some of the public health community, which is why they were required but may be empty in the first place.

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

I don't understand the distinction between required and may be empty in optional.

Rita Altamore

Welcome to the wonderful world of HL7. Essentially what required but may be empty says is that the system has to support those elements, which again from the perspective of a submitter would say you have to have them in your system. So they are “required” but recognizes that in some cases you may not have the information to put in that field in a particular transmission and so it may be empty in a particular message. But you have to demonstrate that you have the capacity to send that information if it exists.

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

Okay, That’s helpful. It sounds like some changes to that document may be forthcoming. Whether or not we’ll need to have another public review, I guess we can be informed by people at ONC, or maybe CDC. I don’t presume to know that. But at least our recommendation would be presumably based on that revised document. I am mindful that we are two minutes away from a public comment period; no, no, we’re not, we’re seven minutes away. Other questions or issues that we haven’t discussed? I think we’re in a position to make at least a preliminary draft of our letter and discuss it on a health thread or?

Rita Altamore

Chris, this is Rita again. Are we going to make any statement at all about the absence of an implementation guide for eligible providers?

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

I think we’ll be obligated to point that out. I think the implementation guide for hospitals is, what exists? That’s a fair question. If it’s moved, I presume, from a menu item to a required item and does that mean that it’s required for eligible providers and not just hospitals? I guess that’s yes.

M

That’s under consideration. That was a question opened by the Policy Committee not yet answered. It may be partly entered on the basis of what will be available by Stage 2.

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

Okay, then maybe our recommendation could be that it’s required for hospitals but not for eligible providers, given the complete absence at this time of any implementation guide. That sounds rational.

Rita Altamore

This is Rita again. I think there’s also some discussion, and Taja can certainly address this in more detail in the public health community about exactly how would we construct syndromic surveillance from eligible providers in a way that would be most useful to public health and also least burdensome to providers. There’s just not as much experience with getting that type of data from providers as there is from hospitals and EDs.

M

Right. I believe that, and Taja can speak to this, obviously, that the process that he has initiated will address that question as well as the content and the implementation guide issues. I guess I heard Chris’ statement as a motion that in the absence of a suitable implementation guide by date “x” the committee might recommend not making this a required reporting item.

Rita Altamore

In Stage 2?

M

That’s correct.

M

And what would be the date that you’d like to consider, because Stage 2, again, it goes a little bit to if we have three years to get there are we willing to suspend belief for a year to see how successful the implementation guide effort is. So what would be the date we would like to see?

M

I think, unless Judy tells me otherwise, we as our little committee are required to render an opinion as to what we think should be recommended in Phase 2, and I think based on that requirement and we have to do that by September, based on the fact that there is no implementation guide I'd be hard pressed to make a recommendation that eligible providers should be required to do that reporting. I understand what you're saying is that conceivably in the next year by the time eligible providers have to do this the implementation guide could be ready, but I think that's a disservice to eligible providers in that if they get the implementation guide the day before they're supposed to demonstrate --

M

I guess it's my understanding that we anticipate the guide to be available, and correct me again if I'm wrong here, Taja, we expect it to be available approximately two years before ... the document.

Taja

Yes, that's correct. For the eligible provider as an outpatient we're going to start that process this fall and hopefully end by next summer, realizing there's not a whole lot of work that's been done out there with eligible providers. However, we are going through the ISDS ... to identify some individuals that can commit to this process for the next year and a half and have had some experience with outpatients. It's not as easy as emergency room departments. Also, we're going, over the next couple of weeks starting the process of identifying what is truly core and what can be optional. We don't think it's as difficult as it is considering some of the elements for demographics and things like that are already required for meaningful use by some of the elements for syndromic surveillance from the patient perspective, like chief complaint, initial diagnosis, etc. There are two or three elements there that can be optional, like measure temperature for pulse oximetry and some other things.

Seth Foldy – Wisconsin – State Health Officer

This is Seth. Chris, if you'd accept an alternate motion for consideration, that we note the absence of an implementation guide and that we recommend that a conditional requirement for EP syndromic surveillance reporting be created with the understanding that if the Standards Committee does not endorse a messaging guide by, let's say, September of next year, which would be two years before the need to implement, that that conditional requirement be dropped.

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

Well, we can certainly try it. I have no objection to proposing that. I don't know what ONC would do with it.

Seth Foldy – Wisconsin – State Health Officer

Understood.

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

I don't know if they can take the conditional recommendation thing, but we'll see. We are at 9:55, and thank you, everybody. We will clearly schedule another call and we will clearly distribute among you a draft of a letter. I guess I'm on tap for drafting that, unless somebody else is going to do it for me. With that, Judy, let's consider public commentary.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Chris. Operator, can you check and see if anybody wishes to make a comment?

Operator

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

Judy Sparrow – Office of the National Coordinator – Executive Director

All right, thank you, operator. Chris, thank you, and thank everybody.

M

Thank you, everybody.

W

Thank you.

M

Thank you.

M

Bye.