

# SIG Power Team Draft Transcript August 4, 2011

## Presentation

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good morning, everybody, and welcome to the Standards Committee Surveillance Implementation Guide Team call. This is a Federal Advisory call, so there will be opportunity at the end for the public to make comment. And just a reminder, members, please state your name when speaking. 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?

**Sharon Terry – Genetic Alliance – President & CEO**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Walter Suarez?

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Ken Mandl? Marty LaVenture? Seth Foldy?

**Seth Foldy – Wisconsin – State Health Officer**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Rita Altamore?

**Rita Altamore, MD, MPH – Washington State Department of Health**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Taja Kathote? Priya Rajamani? Anna Orlova?

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jim Daniel?

**James Daniels – Medical College of Wisconsin – Associate Director**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

And did I leave anybody off? Alright, with that I'll turn it over to Dr. Chute.

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

Good morning. Let's do an agenda check. I think our main body of work is to address my fairly incomplete and rough draft. Are there other agenda items people want to propose? Hearing none, let's turn to the document. My apologies for delivering it in a time that gave you very little review opportunity, basically an hour. I finished it late last night. I'm on vacation. Sorry.

That being said, I've list structured it so that we're talking about the introduction, then the three recommendations and then the future option. I think the most pertinent gap in the introduction is perhaps I've left people off that should be here, in terms of membership. Is it Jim Daniels?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes. Jim is with ....

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

Okay. Should he be part of this group or, Judy, should you be part of this group?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

No. I have this all on a distribution list, so we're covered.

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

Okay, fair enough. So, let's turn discussion to the introduction component. I'm happy to take additions, changes, deletions, whatever makes sense for you. By the way, I should hasten to add, this is not our only opportunity to comment on this draft. We will send out another one at the end of this call to the entire membership. I expect we can have some electronic dialogue over the next several days or so. We are not really obligated to have a near final draft, just a penultimate draft, until the presentation to the Standards Committee for approval on the 17<sup>th</sup>. They may make some modest recommendations or changes after which we will forward this to ONC. That's my understanding of the timing. That being said, comments on the introduction? Did everybody get the letter?

**W**

Yes.

**M**

Yes.

**W**

Yes.

**M**

Just reviewing it now.

**Rita Altamore, MD, MPH – Washington State Department of Health**

This is Rita Altamore, and because of the time on the west coast, I did not get a chance to read it before this instant.

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

I'm shocked.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Yes, really. I'm at a similar disadvantage. And thank you, Chris, for doing this on vacation. I think the introduction looks good.

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

We'll give people another minute or two to read it over.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

With all due respect, this is Anna Orlova, what do you call introduction? Is there a special section there? It looks to me, well this is the first paragraph.

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

Basically, everything up to and including bullet point one, Electronic Laboratory Reporting, I'm calling introduction.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

Okay, thank you.

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

I should add, I wrote this in a car last night on my way home from the King Tut Exhibit in Minneapolis. So, there you are.

**Seth Foldy – Wisconsin – State Health Officer**

I think I'm a little confused by the indented bullet under syndromic surveillance, whether or not that bullet—I take it that goes to reflect specifically the syndromic surveillance implementation guide?

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

Correct.

**Seth Foldy – Wisconsin – State Health Officer**

I know that what we've done so far is kind of—we've done some level of assessment of the draft for comment implementation guide that's been distributed already for hospital and emergency room syndromic surveillance. I guess I'm not sure I know entirely what that bullet is trying to say.

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

I think the purpose there is that we focused our discussions really on those three items. And in the case of syndromic surveillance, we included discussion about the implementation guide. Would it be more clear, Seth, if I were to add implementation guide for syndromic surveillance? Mind you, it is expanded in the point three below to some extent. This is simply the framework and overview.

**Seth Foldy – Wisconsin – State Health Officer**

I guess—I'll just simply say, I'm slightly confused. It may become clearer as we go through the rest of the letter, and then we can change the wording so the clarity is—

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

Okay. If you're confused, I suspect other people will be too. But let's return to that when we get down to that specific recommendation. I'm not hearing a clamor for substantial change. I wrote this obviously to be noncontroversial, at least to the extent I could. Let's move then to electronic lab reporting, which in my opinion is a bit thin. Maybe if I were vain, I'd call it concise. But I think it's actually a bit thin. So, let's discuss electronic laboratory reporting.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Sure. This is Rita. I'd like to propose a couple of small modifications. One of which is, the is distinguished from maybe either we can have that add a little bit with some other differences or among

other things, it is distinguished from and it's not adding additional fields, but there are several. But those are tweaks.

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

Those are exactly what we want to hear, Rita, so let's tweak away.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Okay. So, I can provide, and we don't have to necessarily do the final wordsmithing today, as you said. But I can provide some suggestive changes to the first sentence. I'd also like to expand that section in general with a couple of statements about why it is 2.5.1. It was chosen in alignment with other laboratory initiatives, and it will be in alignment with the outcome of the laboratory results initiative that's currently a process of ONC. So that, I'd like to have that statement in here because people ask those questions all the time about why did we only choose 2.5.1 and why is public health making us do this. Well, we didn't make you do it. We followed your lead, and I'd like to have this paragraph reflect that in some way.

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

Does anybody object to those sagacious recommendations?

**M**

Not at all.

**M**

Not at all.

**Seth Foldy – Wisconsin – State Health Officer**

I would also like to—one of the things in our breakout group really understood very clearly was there is the HL7 version, and then there's the implementation guide. And the implementation guide is actually what's very important. So, I would include language saying that these are implementation guides created in 2.5.1 and 2.3.1. And that we really would like to call people's attention to the fact that the guides go well beyond just what version ... use.

**Rita Altamore, MD, MPH – Washington State Department of Health**

I think that's a great addition. And if I may, I'll volunteer to provide a draft modification to bullet number one to the test and offer that to the group for consideration.

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

That sounds outstanding Rita. I'd be enormously grateful because I think you do have a deep understanding of these issues. And as I said, I knew this was an inadequate summary when I forwarded it, but I was hoping precisely what you're suggesting would happen.

**Seth Foldy – Wisconsin – State Health Officer**

I concur with the volunteer, and I would also add, Seth Foldy speaking, that I think we are interested also in calling people's attention to the importance of implementing the implementation guide, whether or not that's exceeding the scope of this committee might be a question, but that we see one of the challenges going forward to making this a total success is that over time, the EHR or laboratory information system that is part of a certified EHR is actually approaching the quality implementation of the implementation guide because one of the things that we are learning is that there's immense variability in the actual implementation of the implementation guide. And that that implementation is not, for example, called out in NIST certification requirements. So, I don't know how far we want to go, but at least to kind of highlight

that implementation—the quality implementation of the implementation guide needs to be one of the future oriented steps for success here.

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

That's a good issue, Seth, and I—this is Chris—I'm not sure how far we should go because when I read the recommendations for meaningful use, I think the statements you're making about implementation guides are implicitly true for virtually all of those standards recommendations.

**Seth Foldy – Wisconsin – State Health Officer**

I suspect you're right.

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

And have not, to my knowledge, been drawn out so explicitly for most of the other standards recommendations. I think in fact, we are—I think Rita adding the detail about the implementation guide in her draft is highly appropriate, but really it gets down to what is our recommendation. And if I could summarize this, it's really a distinction between recommending HL7 2.5.1 as the only specification versus that plus its associated implementation guides. And I don't—I'll defer to ONC staff on this one. Is there some advantage to, in the recommendation, pointing out the existence and appropriateness of available implementation guides?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jim, do you have a voice on that?

**James Daniels – Medical College of Wisconsin – Associate Director**

I do. Can you hear me?

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

Yes, we can.

**James Daniels – Medical College of Wisconsin – Associate Director**

Okay. Sorry, I've been on mute. I do think that's important just because there is still some confusion, I think, with some states around what implementation guides are supposed to be using. So, I think it is important to call it out.

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

Okay, then we will. We'll add that. Rita if you could, in your drafting of the—redrafting of that intro paragraph for ELR, add to the recommendation the appropriate language. I don't even know how to specify that implementation guide, so no doubt, there's language that can make clear which implementation guide we're talking about. And we can add that to the recommendation.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Absolutely, this is Rita. I guess so I'll ask your question again, Chris, which is if we're going to make a statement in general about how recommending a base HL7 standard isn't sufficient, we are also recommending specific implementation guides in each of these. Is that something we should elevate to the introduction as opposed to being in the first bullet?

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

Yes, I guess. Good point. I will go ahead and take responsibility for modifying the introduction accordingly.

**Rita Altamore, MD, MPH – Washington State Department of Health**

This is Rita again. I think for ELR specifically, I would like to consider including at least one sentence about the fact that our guide, our electronic laboratory reporting guide, does specify the use of LOINC and SNOMED, whereas elsewhere in the final rule, only LOINC was mentioned. I don't know how to do that without sort of opening the can of worms, but that can exists. So, I—and those of us who are on the receiving end know how important it is to get SNOMED in coded results where those are appropriate, but really if folks are sticking to the letter of the final rule, that's not entirely clear because it doesn't mention SNOMED in the context of laboratory reporting. Only our guide does that. So, it's one of those, we know it's there. It's the elephant in the room, but how far do we want to go in this recommendation?

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

I think that's—if the implementation guide we want does include value sets that are drawn from LOINC and another for other use cases, value sets that are drawn from SNOMED, I think we should point that out in the ELR paragraph, paragraphs as it might turn it into, that you're going to draft. Not so much that we're in conflict with prior recommendations because honestly the vocabulary use cases in meaningful use are, how do I phrase this politely, somewhat vague. And the actual instance detail has been delegated for whatever reason to the implementation guide. So, if we're making this specific implementation guide, I think it's appropriate in that opening paragraph to point out that this would include value sets from, and that's the jargon I think they're using this week, and I'll use that, from LOINC as well as where appropriate value sets from SNOMED to satisfy these recording requirements. Does anybody disagree with that?

**M**

No, I think that's right.

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

Yes, I'm not hearing a lot of disagreement. So, no, go ahead, Rita, and please include that observation and our recommendation will stand at the 2.5.1 and the specified implementation guide. I don't think the recommendation need includes such language, but certainly the ELR introduction would benefit significantly from observing that implication.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Will do.

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

Alright, so I think ELR is safely in the hands of Rita. Thank heavens. Without further discussion, let's move on to immunization, which is I think a little more fleshed out but perhaps not accurate. Have at it.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Chris, this is Walter, just one suggestion. Maybe it's worth emphasizing at the end of the paragraph the fact that 2.5.1 does have a number of improvements in terms of the payload, in terms of the data content. So, it's not just single specifications add clarity to standards and recipients that's recommending 2.5.1 provides an improvement in the actual message content as well.

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

If that's true, Walter, and no doubt that it is, I think that belongs in the beginning of the paragraph. I tried vaguely to—I remember hearing noises around inventory management and pediatric vaccination. And that's where I said these fields are supported in 2.5.1. If there is additional content that 2.5.1 supports relevant to the vaccination use case, then I think those fields belong in the beginning of the paragraph. Do you know what they are, Walter?

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

You know the smaller group, I guess or the conference call I participated in the smaller group where if you highlight of that, not a great detail of all the various improvements. But one of them, for example was reduction in variability of the data elements. So, the 2.3.1 standard leaves some variability in terms of data element that can be reported and how they get reported. I think 2.5.1 reduces that—

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

Are you talking the implementation guide or are you talking the technical specifications?

**Seth Foldy – Wisconsin – State Health Officer**

This is Seth. I do believe, and I may be wrong in my language here, but I do believe that there are implementation guides published for 2.3.1. In the Public Health Subcommittee discussion, there was some, apparently the definition of several of the fields in the 2.3.1 specification leaves sufficient wiggle room that they are not as specific as in the 2.5.1 implementation guide.

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

Okay. So, this is helpful. So, what you're telling me is that the 2.3.1 implementation guides; one, there are many of them; and two, they have underspecified some of the fields and values?

**Seth Foldy – Wisconsin – State Health Officer**

I don't know if there are many. There's at least one.

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

Okay. So, the one that exists underspecified fields and values and is not crisp about the value sets.

**Seth Foldy – Wisconsin – State Health Officer**

Is not as useful. Yes.

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

Okay. So, there's only one, but it's underspecified values and not as useful. So, what you're really saying is that the 2.5.1 implementation guide is more precise and clear in the value set specification. Is that correct?

**Seth Foldy – Wisconsin – State Health Officer**

That's what we heard from.

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

Okay. I will cheerfully add that to the immunization reporting. And I think that belongs in the beginning where we're talking about the technical advantages of 2.5.1.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

That will be fine, and the beginning works well.

**Seth Foldy – Wisconsin – State Health Officer**

Chris, if you would like, this is Seth, I'd be willing to take this paragraph, probably walk it over to our immunization experts and try and make sure the language is as accurate and concise as possible, similar to Rita's task.

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

Oh, twist my arm, Seth. Yes please. No, I'd be enormously grateful, and you'd include this language about the specificity of the implementation guide?

**Seth Foldy – Wisconsin – State Health Officer**

Exactly. I'll start taking notes now as to what people are—

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

And Seth, if you could, I think was it Warren that was on the call?

**Seth Foldy – Wisconsin – State Health Officer**

That's right..

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

I think he highlighted a couple of other improvements in the 2.5.1 over the 2.3.1 aside from the improvements specificity. So, you might want to ask him a couple of additional improvements that can be noted in this letter.

**Seth Foldy – Wisconsin – State Health Officer**

Okay.

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

That would be enormously helpful.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

The other suggestion I have is in the recommendation, I think we should also, just like we did with or we agreed to do now with the lab, is mention the adoption of the corresponding implementation specification implementation guide that goes along with the 2.5.1.

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

Yes. Thank you, Walter. I agree, and thank you for emphasizing that. I think we all agreed that all of the recommendations would include language about the specific implementation guides. The only place I had done that was in syndromic surveillance. But yes, this is recommended. So, Seth, I presume you and Warren and others will add language to the recommendation about the specific implementation guide as well.

**Seth Foldy – Wisconsin – State Health Officer**

Right.

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

Excellent. Other advice for Seth and his colleagues?

**Seth Foldy – Wisconsin – State Health Officer**

I think I would prefer to say it may be burdensome, the last sentence, for many providers to support parallel implementation of different interfaces. I know that Chris and Walter have alluded to this, but I do have an uncomfortable feeling, we haven't actually heard from the industry. So, I might want to put that out there as it may, and therefore, allow—if the industry ends up coming back saying you know that making the changes between versions may be more burdensome than adhering to a single version, we'd probably want to hear that on the feedback. And I don't know what we're going to hear. There may be people-- it's possible they all know a lot more than I, and it's definitely more burdensome to support two versions than to go through the process of changing a version. But I'm just not—I'm a little uncertain on that point.

**Rita Altamore, MD, MPH – Washington State Department of Health**

This is Rita. I wonder who it was that asked us to look at going to a single version and was it the implementation community, the hospitals--?

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

The HIT Policy Committee.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Who should be representing that group of folks, right?

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

Walter and I sort of spoke up on behalf of at least large providers where we're acutely aware of the overhead of maintaining parallel issue versions and issues of standards, having translation engines for one purpose running in one setting and different translation engines for a different purpose running with another setting. I can say categorically, that is not efficient. And whether we include the word may or not, I don't feel strongly. It does give some opportunity for—the question is whether it's burdensome for many providers, for some providers. That's the other place for wiggle room. I will defer to your judgment, Seth, as to how you soften that. I acknowledge that it is far from a comprehensive survey of providers that have informed the statement. And for that reason, I can agree to some modifying language or mitigating language.

**Seth Foldy – Wisconsin – State Health Officer**

And I'm perhaps partly expressing my ignorance. So, it sounds like-- I'm happy to leave it alone.

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

Chris?

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

Yes.

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

Hi. This is Marty. I'm sorry I was a little bit late. Just I guess I would also endorse the language that Seth is talking about because as I recall, Warren mentioned that they are investing, CC's investing considerable amount of funds in moving this state information systems to 2.5.1. And at least in Minnesota, there's only really a handful that have actually implemented it. And so, I think part of the strategy, as I recall, that was discussed is that if you're going to 2.5.1 anyway, go sooner for less pain than have everyone implement 2.3.1 and then switch to 2.5.1 since that's the path. So, recognizing there's some pain, but it's going to be less pain than should we wait and do this in a year or later.

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

Yes. I agree, Marty, that was stated.

**Seth Foldy – Wisconsin – State Health Officer**

So, I'll add some language on it. This is Seth. And also state that any change for a single standard may require that some providers who are meeting this current standard using 2.3.1 will, of course, have to make a switch, and there will have to be a re-onboarding by the public health system. And that these are obstacles that it may be good to minimize this obstacle by announcing our intent early as this letter does, which incorporates Marty's point.

**M**

Well, fair enough, but I wouldn't dwell overly on the pain of transformation because let's see what language you come up with. My concern is we make it look so bleak that we're discouraging people from

even thinking about it. When the reality is, at least what I heard from Anna say, that most implementations aren't using 3.1 or 5.1. They're using idiosyncratic or proprietary interfaces presently. So, the onboarding issue is going to be significant. And I think Marty's point, and I agree with it, is well let's just all use a single paddle in the same direction here as we try to engender this standardization.

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

Fair enough. Are we ready to move on to syndromic surveillance?

**M**

I think we are.

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

And again, I think this set of paragraphs is under informed because I took crude notes and manifest them here. So, your comments?

**Seth Foldy – Wisconsin – State Health Officer**

So, the sentence about expected to be an implementation guide targeted to eligible providers, our current understanding is that there should be a guide suitable for public comment by winter of '12-'13. So, that, in other words, a full year or so before the actual need to implement the guide on a massive scale. However, there will be an implementation guide out there, whether there will be test implementations and pilot implementations with enough time for stage 2 is maybe the issue that might be open to question. Actually, I believe there probably could be.

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

Well, I can say that the tenor—I know what's going to happen at the HIT Standards Committee. There's a group of members who feel that unless a standard has been widely deployed, tested and evaluated, it has no purpose being included in a meaningful use specification. So, if this is the case that the eligible provider implementation guide is not going to be available until the year before, they're going to argue that it clearly hasn't been, it won't have an opportunity to be significantly tested, implemented and so on. So, I think we'd get pushback from members of the HIT Standards Committee if we were to recommend that for Phase 2 under those circumstances. I think it's perfectly appropriate to say that maybe that the eligible providers could be considered for Phase 3 implementation given the timing of this guide. And I guess I hadn't picked up that the eligible provider guide was in fact in process. It was just later out, which is of course a material fact and should be corrected in this document. But as far as recommendations are concerned, I'm wondering, Seth, if you think we should temper that and not push it too quickly because there's already a lot of dissent over what are called hypothetical standards by some members of the HIT Standards Committee being pushed prematurely for meaningful use specifications.

**Seth Foldy – Wisconsin – State Health Officer**

Yes. I guess I wanted to change the language because I believe a guide will be published, which is different, as you pointed out, from saying it's ready for national adoption on a mandated basis. So, I think we might want to put the phrase in that the creation of an EP guide is in progress and is not expected to be delivered until winter of 2012, just for accuracy's sake.

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

No. I agree. And I accept that statement and will take point to do so. I'm looking at the recommendations however, does that imply and would you agree that we would further recommend that eligible providers be considered for syndromic surveillance reporting using the upcoming implementation guides potentially for Phase 3?

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

I think that's already in the, if I'm not mistaken, the recommendations of the Policy Committee which state that it's sort of a signal for Stage 3 where CMS to consider whether eligible professionals will be expected to comply with syndromic surveillance metrics. So, I think it's already there.

**Seth Foldy – Wisconsin – State Health Officer**

My recollection is within the CMS should consider category, but that they didn't specify a stage.

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

Right. And I guess it's our task, quite frankly, as a summer camp and task force to recommend to, if we believe it to be useful, recommend to Standards Committee that they - sorry that is my son's phone - that they go ahead and add this explicitly to Phase 3.

**Rita Altamore, MD, MPH – Washington State Department of Health**

This is Rita. I guess, for me, it would be helpful to have two separate sections under syndromic surveillance. One addressing eligible hospitals and one addressing eligible providers because I think the issues are sufficiently different. The timelines are different. I think for eligible hospitals, it's pretty simple. It's there in Stage 1. We've got a guide. And I think your last sentence there should say September 2011, and we think that that's going to be good to go. And so, I think that's one chunk of a discussion. And the chunk of discussion about the eligible providers is more complicated because it is in Stage 1. Eligible providers are—there is a syndromic surveillance criterion for eligible providers in Stage 1. And I think it would be very helpful if our group could make a clear statement about how we think that should be handled now today for eligible providers. I'm not sure whether we're going to be able to do that, but I know in my community, it would be very useful to have guidance from the federal level about eligible providers because there's a lot of confusion out there.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

This is Walter. So, the reason why this change is because in Stage 1, of course, is where many new options. So, yes, eligible professionals could choose to do syndromic surveillance as one of the many options. For Stage 2, this is going to be moved to core, then the discussion came as well we cannot force eligible professionals by making this a core. So, that when they ... it, and they said okay we'll make it core for hospitals and then we'll just leave eligible professionals out at Stage 2. And so, they ... actually from being even a menu option to not being a part of the meaningful use for Stage 2. And they, as I mentioned, they put it on CMS to consider whether they would include eligible professionals into Stage 2 or even Stage 3. I agree, I think we should separate the two because they are kind of mixed together in these paragraphs. I don't think I'm ready to really support a recommendation that will certainly have eligible professionals be required to participate in or do syndromic surveillance in Stage 2. Certainly, I don't think we—I don't know that I am ready to just agree on even Stage 3. I'm not sure we have enough deliberation or discussion about that here. So, my sense is that we should support, of course, the concept of a single standard for syndromic surveillance 2.5.1, define implementation specification and then for eligible professionals, given that the implementation specification is not even out there and that there isn't yet enough evidence to support the expectation, that every eligible professional that has an EHR would have to support syndromic surveillance. I think we should leave that as an open option and not recommend it to be even in Stage 3.

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

Go ahead.

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

Chris, this is Marty. It seems like we've got a couple of issues here. One is looking at the issue of standards seems to be our responsibility of not necessarily of when is it appropriate to put syndromic surveillance into Stage 2 or 3. It still remains controversial in terms of its value even in the public health community. And so, I think we could make some statements that would say should it be in those stages, this is the appropriate HL7 message standard that would seem to be consistent at this time given things are either moving forward or if it's an option. But I think we have to be careful not to assume that we would be making a policy recommendation for the stage as opposed to a standards recommendation.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Marty, that was precisely my point. The policy committee already has spoken on this. I agree. I think it would be a conditional statement about if the policy decision is made by CMS because now it is in the hands of CMS. The Policy Committee is not going to take action on this anymore. So, it's a policy decision made by CMS per the Policy Committee recommendations to include eligible professionals in the syndromic surveillance as part of their core requirements, then the standard should be 2.5.1. And then, I would say a rapid development testing of the implementation guides for eligible professionals to be underway because that's the problem. The standard's there, but we don't have implementation guide for eligible professionals necessarily in place.

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

I have no problem, this is Chris, with these things being conditional on policy statements. I agree our scope and venue is really the standard specification. Is that correct, Marty? That being said, I do think we have an obligation to make a statement one way or the other about whether the standards are appropriate for eligible providers, and I think all we can say is that conditional, as we said in the hospital groups, conditional on the implementation guides having final approval by the HIT Standards Committee, which for the hospital guide is scheduled for September 2011, evidently. We can make it correspondingly early in 2013 if the eligible provider implementation guide is deemed appropriate by the HIT Standards Committee. Then, it may be appropriate, conditional on policy issues, to consider this as a specification for eligible providers in Phase 3.

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

I think that makes sense. This is Marty.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Chris, you said 2013.

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

Well, I heard Seth say that the eligible provider guide would be available in the winter of 2012-2013.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Okay, alright.

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

That means that it would be early in 2013, or at the earliest, in 2013 that the HIT Standards Committee would have opportunity to review it in its near final form.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Because my sense is that if there is, and that's a big if, if there is a Stage 3, a real Stage 3, given the recommendation of moving Stage 2 one year, by early 2013, the regulations about Stage 3 will need to be in progress, I suppose.

**M**

Yes.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

I mean I think it's probably special, but it's important to point out that, that it's in 2013 when the implementation guide for eligible professionals will be available. And so, it's conditional upon that as well.

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

Actually, I'll reserve my point until this discussions concluded.

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

Other discussion on syndromic surveillance?

**Seth Foldy – Wisconsin – State Health Officer**

This is Seth. The fact is there are probably some pairs of providers and public health providers, although I can't swear to this, who may be exchanging—the ONC rule did not specify an implementation guide, only in HL7 version ....

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Actually, you specified the wrong implementation guide.

**Seth Foldy – Wisconsin – State Health Officer**

But then that was retracted. So, it now specifically says if you're doing this exchange using HL7 2.3.1 or 2.5.1 messages, you're good to go. There may be providers today, and I do not know how many, but I wouldn't anticipate it's very large, who may have a successful relationship with syndromic surveillance consumer using a 2.3.1 format. What I don't think we necessarily need to do is to declare that that kind of syndromic surveillance exchange that's occurring today in a legacy fashion need to be disqualified from meeting a meaningful use objective for incentive. So, in other words, I think it might be important for us to limit our language to say that ONC or the Standards Committee, whoever is the official body, may not be in a position to adopt an implementation guide by a certain date. But that we shouldn't be over reading it into saying that senders and receivers who have accomplished this task should in some way be penalized for having done so.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

That's an interesting observation, Seth, because what it sounds is like we could—so, the Policy Committee said for hospitals, make this core. What we could, based on your suggestion, which I really I think I like, what we could suggest is that yes for hospitals make syndromic surveillance reporting core but still keep it as a menu for eligible professionals—

**Seth Foldy – Wisconsin – State Health Officer**

Given the absence of a broadly approved implementation guide.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Don't drop it in other words or clarify that it should not be dropped as a metric.

**Seth Foldy – Wisconsin – State Health Officer**

Again, that may exceed the scope of this committee.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Yes, I know.

**Seth Foldy – Wisconsin – State Health Officer**

I think our language should basically reflect that, at present there is no established national standard implementation guide for eligible provider syndromic surveillance. Such a guide is unlikely to be available until at least the winter of 2012-'13. Thus, it will not be possible to endorse a specific implementation guide for this community until later. And then, we could—I guess what I'm suggesting is we might want to simply leave it there or we could say it is possible that there are pairs exchanging data using 2.3.1 consistent with the current language in the ONC regulation and that we see no reason why this might not potentially continue. But again, I wish I knew how many there were out there. I do not.

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

Well, this is an interesting notion, Seth, but this goes back to the core agreements that I think we eventually came to consensus to last time that we want to focus both the providers and the public health community on 2.5.1.

**Seth Foldy – Wisconsin – State Health Officer**

No, I'm not questioning that.

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

Well, actually leaving it open that 2.3.1 would continue to be appropriate does ... that.

**Seth Foldy – Wisconsin – State Health Officer**

I shouldn't have specified HL7 version. I don't necessarily—I guess what I'm saying is exchange that doesn't use an implementation guide. But you're right. I would be implying that we would be allowing 2.3.1 exchange to continue to count, so to speak, towards meeting public health objectives. And that may not be the intent of this committee.

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

No. Okay, so if we get that little version issue out of the way, the rest of your point is still salient, which is if they are successfully exchanging data absent in implementation guide, that could continue to count as a menu item, which I think is what I heard you say, but it can't be a core item in the absence of an implementation guide.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

That sounds like reasonable language.

**Seth Foldy – Wisconsin – State Health Officer**

It may also be—I think we also, so let me ... at this point. Again, if you have successfully established relationships and you're willing to acknowledge those, does it matter what version they're in until you actually have an agreed upon national implementation guide? But that's—I'm wondering if we need to specify all that.

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

I would choose not to specify that because I don't want to give mixed signals. I think under specifying it so that if they're doing it regardless of their version, it would implicitly count, I have no problem with that. But to point out that that would include 2.3.1 versus 2.5.1 is a message I'd rather not signal.

**Seth Foldy – Wisconsin – State Health Officer**

Alright.

**Rita Altamore, MD, MPH – Washington State Department of Health**

This is Rita. Just to complicate matters still further, what if they're doing it in a manner accessible to both sides to submit around public health but they're not using HL7 at all?

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

That would not count.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Okay. I guess I was ... find out where our floor was.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Even in Stage 1, that wouldn't count because they must at least do 2.3.1.

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

All of these discussions do have me a little bit worried about the possibility of disrupting legacy relationships, but the group seems to have a pretty clear direction on that.

**Seth Foldy – Wisconsin – State Health Officer**

Okay.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Of course, all this just might be just a matter of clarification from ONC about what happens when a measure becomes moved from menu to core but for only one group, in this case eligible hospitals. What happened to the metric for the other group? Does it stay menu automatically or like most do core for those? Because I think that wasn't clear in the recommendations from the Policy Committee.

**Seth Foldy – Wisconsin – State Health Officer**

One thing that was clear at the Policy Committee was you can't have a menu that consists of a single item. So, if there are no other menu items, there will be no menu item for syndromic surveillance. You have to have a choice before you can have a menu.

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

Understood. But I think we can make that, at least from a standards specification, the case that it might be appropriate for it to be optional or menu. I don't know what language to use, but it's clear that for eligible providers, it would be, our recommendation, would be that it would be inappropriate for it to become a core measure in Phase 2 in the absence of any implementation guide.

**Seth Foldy – Wisconsin – State Health Officer**

I think that sounds reasonable.

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

Okay. I will take point then on sprucing up this set of paragraphs reflecting our conversation. Let's move on to strategic considerations, a model of concise language. Either that or it's grossly underspecified. I'll leave that to your discretion.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

Chris, I would suggest we will remove would message off the CDA in between CDA and format in first line.

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

Okay.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

Because we agreed that we are not focusing on version three, HL7 version three, in our recommendations but only on the ... document, CDA.

**Walter Suarez – Kaiser Permanente – Director, Health IT Strategy**

Yes. This is an interesting point, Chris, that keeps coming back and is the confusion between HL7 versioning and CDA. And I think it's going to be valuable to clarify that you can do CDA using 2.3.1, 2.5.1 or 2.8 even in HL7. So, CDA is not a replacement of 2.5.1 or 2.3.1.

**Seth Foldy – Wisconsin – State Health Officer**

Well, actually I beg to differ, Walter.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

Yes, me too.

**Seth Foldy – Wisconsin – State Health Officer**

The 2.5.1 and 2.3.1 have fairly explicit segments and fields and you populate them and send the message and ... and that's HL7 version. Now, you can send an, I forget what the segment is, an OBX or some segment that is a variable content. And you can package a CDA into an HL7 version 2 message, but it is no longer a 2.5.1 message for a particular purpose. It is a bundle CDA. Now, I agree that we're not being explicit about version 2 versus version 3. I think version 3 discussions are a nonstarter. The fact that CDA incorporates version 3 technologies is a virtue and feature of CDA, in my opinion. But I believe the recommendation we're making is to at least give signals that a strategic move towards CDA is being contemplated by the larger community, whereas the question of whether it's a version 3 or version 2 is immaterial to our strategic consideration.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

In light of what you said, I specifically began thinking that removing word message between CDA and format in line one suggests there would be less confusion then.

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

No. I've accepted that change.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

I also have a suggestion for the examples that you are listing in line two and three. I just would like to suggest that after reportable diseases, you also will add comma maternal and child health and other.

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

That sounds quite reasonable.

**Seth Foldy – Wisconsin – State Health Officer**

I concur. This is Seth. I would probably remove the term large segments. We could simply say the public health community is experimenting with CDA message formats to cover a broad spectrum, whether or not we'll actually get to full is uncertain. For the benefit of the group, again, our public health members of this committee did talk some this week about whether we wanted to signal that things like immunization reporting and electronic laboratory reporting and syndromic surveillance reporting might collapse into a single standard as early as Stage 3. And we came to the conclusion that as attractive as that might be, we think that sending that signal would probably be premature and that we are willing to allow that kind of messaging to become mature and that a lot of our focus in CDA may relate to other types of information such as those mentioned in the sentence. So, the use of the word all full spectrum, may be a little too broad. Broad spectrum would probably be more appropriate.

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

I've accepted your changes. So, large segments are gone. The full was changed to abroad. Sounds fine to me.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

I have a question for the committee. In the light of what's being stated right now here, are we excluding immunization syndromic surveillance and laboratory reporting from the experiments with CDA?

**Seth Foldy – Wisconsin – State Health Officer**

I think the intent is to avoid prematurely sending a signal that they would be forced to change in an ONC standard. Now whether or not they might be allowable in Stage 3 would obviously have to depend on the readiness of the implementation guides by Stage 3.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

My question here is that because right now, it's not clear, how item four connects to previous domains sections. And I think when we find some word in here that just makes it link. To me, strategic considerations of this stage from what was written above.

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

That was somewhat deliberate. I see your point though. And I think we've implied in previous discussions that what Seth just explicitly said is that there may be a duality where CDA might be acceptable for some of these things. I honestly think it's premature to make such prognostication where we're uncertain of the maturity of the experimentation by that time, the degree of difficulty implementing it. There's too many ifs, and I would personally be a little uncomfortable making the explicit linkage between the previous three segments and this strategic consideration. I think what we're doing is we're floating a balloon. We're signaling that this may be a technology base that has more flexibility and frankly viability, but we're stopping short of saying at this time, whether or not this could or should play a role in Phase 3 with respect to the three message formats we've articulated.

**Seth Foldy – Wisconsin – State Health Officer**

So, we're not saying that there won't be potential option in Stage 3, but sending the signal about a potential option in Stage 3 may create expectations and pressures that we're a little unready to address.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

I do understand exactly what you're saying, and I am full support from what you're saying. But other people may read this document and the same question as I have may be raised. So, just if some wording could be edit here to .... Now, the further question that I brought up that may be is for ... Committee. The committee feels that just be presented as is. And I'm fine with that. Just on clarity, that's what ...

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

I think you raise an important issue also in that the Policy Committee did call out cancer reporting as a potential case for Stage 2. And we haven't actually explicitly addressed to the Standards Committee if we believe that that is a suitable standard to go forward.

**M**

Is there an implementation guide available for cancer reporting at this time?

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

My understanding is that there's a—well there's an IHE, and Anna will probably correct me if I misstate, but there's an IHE profile that has been validated once.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

This profile is for pathology report, which is a lab report, pathology lab report. So, that creates even more confusion with okay, we're not recommending CDA for laboratory reporting at all, but in fact, there is a domain that is considering CDA, such as cancer, which are already experimenting with the laboratory reports.

**M**

The other thing I think is we don't have a vested and in place guide for that.

**Seth Foldy – Wisconsin – State Health Officer**

Actually, my understanding may be wrong, but my understanding is that there will be pilot implementation of a CDA data extract from the EHR, primarily for ambulatory clinicians, to cancer registries that will actually be tested over the next several months, less than one year. And that is different, distinct from the pathology report, which is a different standard altogether.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

You're correct, Seth. For cancer, there are two of the same implementation guides that will be available. I respect the cautious approach because it's very healthy to have public health ... but I just confusion in between sections of this document is something that might make feel that when we do a better job.

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

This is Marty. Just a quick thought here, I think the value of this paragraph in the context of our scope, I think, brings several items. One, it, in a sense, reaffirms the above, that indicates that HL7's been in use in the public health community for some time particularly in immunizations and other areas. And that that is solid and continuing. But that there, in the spirit of can we consolidate public health standards, I think this is an important recognition that for areas of consideration for future meaningful use, there are emerging CDA formats that could play a significant role. And I think that that recognition is important. And perhaps our recommendation should be that this is emerging quickly. It's experimentation. This needs to be followed at a little faster paced timeline than perhaps the HL7 guide development. And that this is an area to both watch and learn from and perhaps revisit. And so, I think it's important to point it out. It's important to recognize it in that context. So, like I said, that would be my suggestion because even turn it into a recommendation for continuing monitoring.

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

Okay, let's hold that thought. Jim Daniel, please. Jim?

**James Daniels – Medical College of Wisconsin – Associate Director**

I'm sorry. I just stepped away for a second. Can you actually hear me?

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

Yes. We can hear you.

**James Daniels – Medical College of Wisconsin – Associate Director**

Oh, earlier, I was trying to make comments, and no one could hear me. Could you repeat the question you had for me?

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

Well, I heard that you had wanted to make a comment. So, I'm calling on you.

**James Daniels – Medical College of Wisconsin – Associate Director**

Actually, all my points were made. Thanks.

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

Okay, thank you. Back to your point, Marty, of perhaps in putting in an explicit recommendation because for strategic considerations, I chose not to include a recommendation. But you're raising good merit for actually doing so. And that recommendation essentially would be that we proactively follow, the HIT Standards Committee, proactively follow the fairly rapid evolution of CDA formats associated with public health, I keep wanting to use the messaging word on it, with public health content in a way that might merit consideration sooner than otherwise anticipated. I'm hesitant to say for Phase 3, but I could be persuaded.

**Seth Foldy – Wisconsin – State Health Officer**

So, I like the fact that we are sending a signal here that's CDA may come over the horizon in time for Stage 3, but we're probably not ready to make any recommendations there, except perhaps what might be useful would be to encourage this act of exploration at all—to encourage it, and I think the letter in some ways, does that. The reason I'm bringing—kind of apologize, it wasn't clear how neatly this fit into the scope of such a short timeframe power team, but this cancer issue is something that the Standards IT Committee will be forced to wrestle with given that the Policy Committee called out the cancer CDA specification as an issue for CMS to consider in Stage 2. And so, we had enough on our plate that we didn't sit down to read the cancer specification and determine its readiness as a power team. But I suspect at some point, the Standards Committee is going to be forced to do so. And that perhaps, raises the issue of whether this committee should, this power team continue to exist explicitly to do that or not.

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

Well, I am pretty sure that we're in the context of a summer camp activity, and I believe that ONC's goal was that we would do our work and then get back to other work. So, I doubt very much they'd want to continue. With that being said though, you raise an interesting question, if we failed in our scope to appropriately consider the cancer reporting use case, and whether that's—we've already reported to HIT Standards our preliminary scope on the three messages we've focused on, and I don't recall any call out or pushback on the cancer reporting issue from the Standards Committee. That's not to say that they know everything. How incomplete do you think our report will be without some comment on cancer? Is that something we should try to do in the next week?

**Seth Foldy – Wisconsin – State Health Officer**

I suspect they ... perhaps say we note that the Policy Committee has called out the possibility of cancer registry or something and we were or we're not able to address the readiness.

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

Well, I think—okay fair enough. I agree that we should acknowledge that this has been called out. And maybe we can fairly address the question by saying we think it is an important instance of a CDA format pilot and example that should be carefully watched for possible expansion to other modes of public health reporting and leave it at that.

**M**

That sounds good.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

Just quick comment. If you can use HL7 in terms of CDA, Chris, just showing that in fact this is the HL7 standard.

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

Sure. I can do that. I have no objection to that. That's accurate. Good. Well, I will also take a crack at revising for consistent with the language and comments that have been made. I'll send out markup version of sections three and four. Rita, you're going to work on section one.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Yes.

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

And Seth, you and your colleagues are going to work on section two.

**Seth Foldy – Wisconsin – State Health Officer**

Right

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

Let's informally agree among ourselves to target, I don't know, Monday morning. Is that going to push it too hard for a penultimate version? We can all complain about it bitterly, but we'd have to submit this-- Judy, our meeting is on Wednesday, isn't it?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes. So, we really need to have this complete by say the 15<sup>th</sup>, COB on the 15<sup>th</sup>.

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

Okay. What's the day of the week?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

That's Monday, the 15<sup>th</sup>.

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

Okay, so we have to have it completed by the end of that day. So, let's commit to circulate early that morning our drafts.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Of the 8th, right.

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

Oh, I'm sorry. I'm a week off.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

You have a whole week really.

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

Oh, okay.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Luxury Chris.

**Anna Orlova, PHD – John Hopkins Bloomberg School of Public Health**

On the time.

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

Okay, so why don't we say by, what do you think, Tuesday afternoon is going to be a good deadline or do you think you can get it done by Monday?

**Seth Foldy – Wisconsin – State Health Officer**

I'll go either way.

**Rita Altamore, MD, MPH – Washington State Department of Health**

Yes. I'll target Monday.

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

Okay. Let's target Monday; Monday, noon-ish, eastern time. And we'll distribute that to our colleagues, entertain a couple of days of electronic commentary and change on it. And then, hopefully have a near final draft by the end of next week that should comfortably make our Monday next deadline.

**M**

Would members of the committee want to see information about this cancer CDA implementation or is that going to be overload for us to consider, recognizing we may not make a recommendation? I'm just thinking for the information of the committee and for the power team and the committee.

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

Well, I see no harm distributing it, but I think we've concluded that our recommendation is going to be to look at that within the context of a larger CDA potential.

**M**

Understand. Well, I will send materials then.

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

Okay, sounds reasonable. Other business?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

I think we just have the public.

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

Okay, then let's proceed with the public.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Great. Thank you everybody. Operator, can you check and see if anybody from the public wishes to make comment?

**Operator**

Yes. We do not have any public comment at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. Thanks everybody.

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

Thank you.