Conditions and Maintenance of Certification Requirements Task Force

Transcript
March 28, 2019
Virtual Meeting

Members/Speakers

Name	Organization	Role
Denise Webb	Individual	Chair
Raj Ratwani	MedStar Health	Chair
Carolyn Petersen	Individual	Member
Ken Kawamoto	University of Utah Health	Member
Sasha Termaat	Epic	Member
Leslie Lenert	Medical University of South Carolina	Member
John Travis	Cerner	SME
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator	HITAC Back Up/Support
Mike Lipinski	Office of the National Coordinator	Staff Lead
Kate Tipping	Office of the National Coordinator	Staff Lead
Christopher Monk	Office of the National Coordinator	SME

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Hello, everyone. Welcome to the Conditions and Maintenance of Certification Task Force. Acknowledging we do have a relatively small group today, but we're going to proceed in the hopes that others can join. So far, we have Denise Webb, Les Lenert, and John Travis. We will try to get through as much of today's discussion as we can with reviewing the progress of our draft recommendations, and then we will resume again tomorrow. So, with that, I will hand it over to Kate Tipping for a quick review of the charge, and then we'll get started.

Kate Tipping – Office of the National Coordinator – Staff Lead
Sure. Thanks, Lauren. So, the overarching charge of the Conditions of Certification Task Force is to provide recommendations on the application, programming, interface, real-world testing, and attestations, conditions, and maintenance of certification requirements, updates to the 2016 edition Health IT Certification Criteria, changes to the ONC Health IT Certification Program, and deregulatory actions related to certification criteria and program requirements.

Denise Webb – Individual – Chair
Thanks, Kate. Do we have – I don't know if you can pull up either our slides with the recommendations or the Google Doc? And maybe if you wouldn't mind keeping track of any points we make here as we go along. I do have the notes from the HITAC meeting in front of me. And maybe we can just step through our recommendations, and we'll fly by the ones where there really wasn't any discussion and give people an opportunity to go on if there's something else you wanted to add. So, the –

Kate Tipping – Office of the National Coordinator – Staff Lead
And I'm just going to scroll down here.

Denise Webb – Individual – Chair
Yeah. So, the first one was on the clarity and rationale for maintaining a 2015 edition. Interestingly, I was on a time call with a group of CIOs that make up their policy steering committee. And I know there was some concern – at least, with what I understand – that one of the reasons ONC modified the 2015 edition versus creating a new edition for all of these changes – I don't know if you all remember or note that Steve Posnack had said in the HITAC meeting that ONC thought that the changes were minimal. I don't think – I mean, I personally don't agree and neither do any of the other CIOs. They think it's pretty substantial, and they actually believe that it's much cleaner with this number of changes and the information blocking and the conditions of certification and maintenance being added to the program that it would make sense to title a new edition.

So, I don't know if we want to just – I mean, I think our recommendation stands here. I think they should introduce a new edition of certification. And it's not going to have the negative reaction that maybe ONC might think from the healthcare community – provider community.

[Crosstalk]

Denise Webb – Individual – Chair

I just wanted to share that. Go ahead.

John Travis – Cerner – SME
No, I was just going to say I agree. I heard that – and I think it was Beth Meyers at ONC who made the comment that one of the major reasons they didn't suggest a new edition was the work that the agencies – CMS, ONC, other program agencies that might reference the use of certified EHR technology would have to go engage in regulatory changes to give recognition to a new criteria edition. I mean, I understand that, but I feel like that's nothing that new, that you've had to do that before. The greater burden would be on program participants trying to reference the necessary version of certified software that they need or, especially given the way that they're handling this, being able to distinguish between the version that would incorporate changes in certified product capability that they may be required to have at a point in time while older versions are still being maintained as active.

To me, I haven't seen a really good explanation of how ONC thinks they'll do that through the ONC CHPL. And there are ways, to me, that you could deal with the regulatory language that ties into what is a recognized active version of certified software, or you could make a broad reference to an effective and active edition of certified software based on a point in time. And maybe that's not a complete solution, but it would seem that you could work on the regulatory language to kind of neuter the fact that if something's retired or inactivated, based on when that occurs, that's informative as to what is available and active. So, maybe save yourself having to update the regulation every time the certification edition changes if you do it right.

Denise Webb – Individual – Chair
So, we'll stand on that recommendation. I think that one's pretty close to final, but we can confirm that with the rest of the task force. All right. The next area is around conditions and maintenance of certification starting with real-world testing. And I don't recall, unless any of you do, any extensive discussion on this area. I'm looking at Sasha's notes. But I have gone out and solicited feedback from a number of CIOs in terms of providers participating in real-world testing. And while there may be some burden for provider organizations to participate, what came out – and this is going to relate to – let me step down here. If you'll scroll down to recommendation eight please, Kate?

Raj Ratwani – MedStar Health – Chair
Denise, sorry to interrupt, but I just wanted to let you know that Raj is here.

Denise Webb – Individual – Chair
Oh, good. Good. And while you're here, we're looking at real-world testing, which was the area that you covered. I didn't recall if during the HITAC – and I'm looking at Sasha's notes – that anything significant came up with our recommendations with real-world testing. But I have been participating in some dialogue with a number of CIOs through Chime. And there was quite an extensive discussion concerning real-world testing of interoperability. That there seems to be an overemphasis on getting data out versus getting data in and having usable data. So, as I thought about that, I pointed out to them our draft recommendation eight. And I think it would serve us to strengthen this recommendation to actually affirmatively suggest that the regulation should specify that real-world testing has to test the use of the information that's exchanged and a suggested definition for that. Let me find my notes here.

So, when a system – and this is what we all universally agree that use is. When a system receives foreign data, it needs to be presented in the same view as the native data. And what we think use is and what needs to be tested in the real-world testing for interoperability is it has to be received and viewable, actionable, and reportable alongside the native data. So, I wanted to throw that out to the group to see what you all thought and if we might make some changes to recommendation eight to strengthen our recommendation. Not to say if the use of data is testing – that if expected, it should be done. I mean, I think it's a really valid point from a number of CIOs and provider organizations. It might be one thing to get the data out – and that could be validated through real-world testing – but what about the receipt and use?

Raj Ratwani – MedStar Health – Chair
Yeah, this is Raj. I totally agree. I think that my view of it is that we should be recommending that key part of real-world testing where it's applicable. And so, I think if there's task force agreement on that, we should absolutely strengthen that one.

Leslie Lenert – Medical University of South Carolina – Member
I agree as well.

Denise Webb – Individual – Chair
And so, Kate had –

Leslie Lenert – Medical University of South Carolina – Member
This is Les, and I agree as well.

Denise Webb – Individual – Chair
I think that Kate's cursor is – oh, thank you, Les. John, thoughts on that? Because this doesn't affect the developer organizations.

John Travis – Cerner – SME
Yeah, I agree because it's a pretty significant scoping of what the test plan would need to reflect.

Denise Webb – Individual – Chair
Right. And this, obviously, is going to align with the USCDI because that's sort of framing what has to be exchanged through the API. And I realize it's going to get broader as we go along, as the USCDI evolves. But I think that it should be able to be received, reviewed, take action on it, and it needs to be reportable alongside the native data. Because I think what a number of folks were explaining is that a lot of times data will come into the EHR and it's in a different place. It has to go – you have to go someplace else to look up the foreign data that came in versus it coming up in the view for the provider to look at alongside their native data that are relative to particular data elements.

Okay. So, maybe when we have – next week, when we have Sasha back and others or if we have more people on the call tomorrow, we can maybe firm up that recommendation. Raj, was there anything else under real-world testing that came up that you recall from the HITAC that we should discuss?

Raj Ratwani – MedStar Health – Chair
So, I'm unfortunately in the car and I don't have my notes in front of me, but I don't recall there being any significant comments on the real-world testing component.

Denise Webb – Individual – Chair
Okay. Well, maybe you can take a look at that. And tomorrow when you join on the call, if we missed anything, let us know.

Raj Ratwani – MedStar Health – Chair
Sure.

Denise Webb – Individual – Chair
Kate, do you recall anything that we might have missed? You also are seeing Sasha's notes.

Kate Tipping – Office of the National Coordinator – Staff Lead
Yeah, I don't have anything specifically that I jotted down here from the full committee.

Denise Webb – Individual – Chair
Okay. And Ken's still not on, right? But Les, anything that you have any concerns with since you weren't originally part – I think you were with us at one meeting. I don't know if you were with us for any of the real-world testing discussions. I just want to make sure that this reflects your agreement.

Leslie Lenert – Medical University of South Carolina – Member
It does reflect my agreement. Yes.

Denise Webb – Individual – Chair
Okay. All right. Good. So, now we're moving on to attestations. I don't believe we had any comments on that. And that brings us to APIs, recommendation 16. I don't see any particular discussion on this role – on that recommendation. Recommendation 17, however, had quite a bit of discussion. And in fact, I went out and did a poll on this too of CIOs. And I think the major concern in terms of which FHIR release is in the final rule is that the general consensus is that it needs to be FHIR Release 4 and that's what we should be driving for, just from me talking to several CIOs. And the biggest concern is one which we brought up. Some of the smaller, less resourced vendors might – it might be a big lift for them. And that was a concern of a number of the CIOs as well.

One thing that we might want to consider, though, when we think about the time frame and the fact that there might be some vendors that would struggle with this but there's also the provider side of this. The rule doesn't really specify how that 25 months gets broken up in terms of how much time we've given to the developer versus the provider organization to implement the changes and have them in production use for care delivery. So, just in terms of clarification, Kate, the 24 months – or I guess it's actually 25 months from the date of the rule being published, is that intended to be the time for the certified products to be available and posted on the CHPL for use, or does that include actual implementation at the customer site?

Kate Tipping – Office of the National Coordinator – Staff Lead
I believe it's available and out to customers.

Denise Webb – Individual – Chair
All right. And so, we can assume out to customers means they have it installed and they've implemented it to train? I mean, I'm just trying to figure out where is the connection between the other programs, like CMS' programs, that require the use of certified technology. I mean, do they have a date? Is there regulation? I mean, I haven't really gotten into the CMS regulations. Does anybody

know if CMS has a date by which the providers have to actually be using the certified technology, the new version of the 2015 edition? Anybody know, or can we find out?

Kate Tipping – Office of the National Coordinator – Staff Lead
Yeah, we can find out for sure.

Denise Webb – Individual – Chair
Yeah. Because if their date is the same as the date that ONC has and it's going to be two years after the final rule – and I don't know which entity's rule – then I think it would be a good idea to make a recommendation around splitting the time so that there's a sum certain amount of time the developers get and a sum certain amount of time that the provider organizations get so that one – the developer entity doesn't use up most of the time and leave the providers hanging with only two months to implement something. Because I know, coming from a provider organization, you can't get things done in just a few months when you're putting out a new release. So, depending on what we learn about the dates, I think – and the reason I'm bringing this up here because obviously there's a lot of development time for some vendors to move to FHIR Release 4 whereas other vendors, I think, are already working on that – right, John? Like Cerner's already working on that and heavily involved?

John Travis – Cerner – SME
Yeah. And I think in general, just the notion of a full rollout and I think of the size of our client base – and certainly, Sasha would reflect that for Epic. You know, we're looking to do some things that will help smooth that generally with how we make software updates available and try to move away from the traditional kind of installed package sort of approach. But it still is a lot to take and adopt, because it's not a small update for itself. And there are more than one of those kinds of timed exercises where you've got to get it done within a set time. You know, 24 months from effective date. Data exports that way and some of the other – you know, e-prescribing could shape up a bit that way. So, yeah. It would be good to get a firm understanding of that. And it's kind of tough to evaluate if it's adequate.

Denise Webb – Individual – Chair
Yeah. And the standard is not yet complete. I mean, so when will it be complete? And should we recommend that, because it's not complete, while it's fine to set a time frame and the time frame should include specificity around how much developer time versus provider implementation time – and maybe there should be – we should recommend that there should be some sort of exception process or a hardship waiver for developers that legitimately need more time. I don't know. This one just – I've been thinking about this a lot and I've been hearing a lot about concerns from the provider organizations about the amount of time being provided.

So, I would note on that, Kate that based on what we find out on the CMS side, that we could revisit this to maybe make a recommendation.

Kate Tipping – Office of the National Coordinator – Staff Lead
Okay. So, I believe the CMS – I believe that they're requiring the use of the 2015 edition by January 2020.

[Crosstalk]

Denise Webb – Individual – Chair

The new one? You're talking about the one that incorporates all of the changes that are in the ONC rule?

John Travis – Cerner – SME
I don't think that's quite right, coming from across the board at least.

[Crosstalk]

John Travis – Cerner – SME
That's for e-pres—well, that isn't even necessarily true for e-prescribing. The ONC has kind of hedged their language a bit to respond to when CMS actually – you know. If they hold the current compliance date, that may be one thing. If they do something like they've done before to decline to enforce compliance or to actually delay the compliance date for the new e-prescribing standard, then they leave themselves room to respond to that. So, I don't think 01/01/20 means anything for the places where there's a time transition for the new criteria that replaces things in the current 2015 edition.

Kate Tipping – Office of the National Coordinator – Staff Lead
Okay. We'll double check then.

[Crosstalk]

Denise Webb – Individual – Chair
Yeah. I do recall that January 2020 had to do with the NCPDP script.

[Crosstalk]

John Travis – Cerner – SME
Right.

Denise Webb – Individual – Chair
Which is part of the certification requirement changes to the 2015 edition that is included in the ONC rule.

John Travis – Cerner – SME
Yeah. And they basically say, "We'll react" –

[Crosstalk]

Denise Webb – Individual – Chair
My sense with the discussion at the HITAC when I'm looking at the notes – let's see, Arien had quite a bit to say about FHIR Release 4. But he did note that that is the release that can address the vault data. But he also acknowledged it's not ready for use today. So, my point about the standard's not yet complete. And he also noted that there's regulatory flexibility. I think Elyse also mentioned that in terms of the standards advancement process. But I think there is overwhelming support for getting to one standard version and going with Release 2 would set the industry behind. So, again, if there is some accommodation for some of those smaller developer organizations with fewer resources to have some process where they could request additional time if it's legitimate, I think we might want to consider that as a recommendation.

I don't know what the unintended consequences of that might be in terms of interoperability. John, would that just mean that others would have to continue to support Release 2 until these smaller vendors got off of it if they got a waiver?

John Travis – Cerner – SME
You know, I don't know enough to say, and we can certainly find out the answer. Are there issues caused by maintaining support for – you know, if this were CDA or if this were HL7 R2, it would impact trading partners. Given with API services, you're primarily concerned with the external – well, with the applications that would engage, you're going to be dependent on their ability to support interaction with you on that release, I'm sure. But it's more of a direct relationship where it's not – maybe a little less two-party interaction where you're worried about what the other HIT vendor supports. You're worried about what the app developer may be able to make use of. But it's going to be more on behalf of the same organization you're providing the – if it's a provider use case, it's probably your own client and the third-party that's been brought to the table. So, like the EHR launch use cases.

Or if it's a consumer app, then you have to worry about their abilities and it's a little bit different or at least feels a little bit different than the concern you'd have with standards backward compatibility in the traditional sense of two-party exchange that is an intermediate exchange. You're dealing with the data, someone seeking access. And it's – I think –

[Crosstalk]

Denise Webb – Individual – Chair
Okay. So, R4, as far as you know – someone said in the HITAC meeting that it has guaranteed forward compatibility, but it doesn't have backward compatibility. Right?

John Travis – Cerner – SME
Yeah.

Leslie Lenert – Medical University of South Carolina – Member
I think the statement was that version four would have backward – and on would all maintain backward compatibility. But say, five, six, seven, would all have to include everything.

Denise Webb – Individual – Chair
Okay. So, that's what he probably meant by forward compatibility. Starting with R4, the next version would have compatibility back to R4. So, that's sort of like the starting point. Okay. So, there's definitely an issue there. I mean, there's no backward compatibility. We have to contemplate that if we decide to make a re—

[Crosstalk]

John Travis – Cerner – SME
Well, and I think – no, I was just going to say that I think in a way, there is an opportunity to set that kind of starting point given that there was no prior standard. Now, I realize that very high degree of adoption of FHIR-based API standards was the reality even given that. But vendors were even then not really mandated to be on a given basis of it. Now, they probably gravitated around a particular basis of it. But just the point is, to this point in time, vendors have not been mandated beyond the market

pressure they deal with. They have not been mandated beyond a particular version, and most of their use of the API services has probably been focused on what are rather specific use cases where they're dealing with a few consumer applications or a few provider use cases.

And they may be using it for things that are fairly well understood within their own install base. So, third-party developers that are working with their same clients, it's more the concern of what those entities can support. I probably wasn't saying it really well, but it seemed like it probably hasn't been exposed to quite the broad issue of backward compatibility that may exist in other standards areas.

[Crosstalk]

Denise Webb – Individual – Chair
Oh, go ahead, Les.

Leslie Lenert – Medical University of South Carolina – Member xyz
Yeah. I think that my understanding is that as FHIR has evolved with DTSU23 approaches and people have worked on it that it was very much intended as a work in progress. I do think we have to encourage that version four is the first really intended release product. It's kind of hard not to say that we would at least take that standard.

Denise Webb – Individual – Chair
Well, I'm hearing on our task force general consensus. I know Ken did bring up a comment that I am reflecting here. He thought giving ONC flexibility to choose the latest makes sense and to have like an **[inaudible] [00:29:16],** for example. I'm not sure. I think he's probably in the same place as we are, but I think we're probably ready on this one. We should take a vote of the task force on proceeding with this option and forwarding it on to the full committee. Because I believe the way it works, Lauren, is Raj and I will be signing out a letter of our recommendations to Carolyn and Robert, to the committee co-chairs. Is that correct?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yes, that is correct.

Denise Webb – Individual – Chair
And they're going to consolidate – and then they'll consolidate everything that is agreed upon by the committee and forward it to Dr. Rucker?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Correct. Yes.

Denise Webb – Individual – Chair
Okay. All right. So, I think we need our whole committee – I mean our whole task force to take a vote on this one. It sounds like everybody that's on the phone today is in an agreement with our recommendation as it stands. But I just want to make sure, because Ken was not available when this was first written and I just want to make sure he's good with it. So, as soon as we get him – if he's on tomorrow, then I think we have everybody accounted for. All right. Anything else on that, or can we move on?

All right. Let's see here. I don't think any of these others – and when that's in red – or is that just tracking? Kate?

Kate Tipping – Office of the National Coordinator – Staff Lead
I think that is one that ken had added.

Denise Webb – Individual – Chair
Oh, okay. So, we need to – yeah. Let's take a look at this as a group. Oh, you went past it. Because I don't think we discussed this one, right?

Leslie Lenert – Medical University of South Carolina – Member
I think that this was a very important comment. It was to say that Argonaut couldn't be named or shouldn't be names as the primary source of anything as a standard because it is a closed group.

Denise Webb – Individual – Chair
I don't really have an opinion on this. I see your point. I guess I would refer to ONC to ask whether regulation text can – yeah. I'm not sure. Well, how would ONC handle this? They would specify HL7 U.S. Core FHIR Implementation Guides – I assume those exist – that are derived?

Leslie Lenert – Medical University of South Carolina – Member
Yeah. That's' what it – the keyword is don't say that it's specified Argonaut. Say it's U.S Core FHIR implementation. Derived from that, you can say those things [inaudible] [00:33:07], but not the Argonaut specification.

Denise Webb – Individual – Chair
Right. So, I guess what I'm asking, does that exist? I mean, once they finish the balloting in all of this, does the HL7 group update their guides based on what Argonaut did? Is there a physical guide that they're going to be able to point to?

Leslie Lenert – Medical University of South Carolina – Member
I don't know.

[Crosstalk]

Denise Webb – Individual – Chair
John, do you know?

John Travis – Cerner – SME
I would assume there would be. We can – let me think of somebody who is involved in it. So, the question is basically for any adoptions or changes under Argonaut that incorporate, are they incorporated into HL7 balloting and –

Denise Webb – Individual – Chair
Implementation guide. Right.

John Travis – Cerner – SME
And implementation guides? Okay. Let me see if I can actually –

Denise Webb – Individual – Chair
I mean, if they – if that's their process, then this is a good recommendation and makes sense. I just want to make sure what we're recommending is the way it actually does happen and that we're pointing to something that is real here.

John Travis – Cerner – SME
Yeah. Let me take a moment. If you want to go on, I'll try to see if I can find out a little bit of an answer there.

Denise Webb – Individual – Chair
Yeah. And if they don't get back to you, we can certainly revisit this. All right. So, we're down to 19. Okay. All right. The next area that I saw comments on was recommendation 21. And I think we can clarify recommendation 21. Let me grab my regulation here – I mean my proposed rule. This was a matter of semantics. We read something verbatim and misin– well, we misinterpreted it. And therefore, it can be written better to avoid the mixed interpretation.

Let me just get to this section. This has to do with the requirement for the vendors to publish their updated documentation on API six months after the rule is final. Let's see here. I am trying to find the page. Bear with me. So, I'm still trying to find the page. So, what it said was it talked about in 170.315, the APIs that were already in the regulation as required criteria, that is what this is referring to with six months. It didn't specifically say that. I apologize. I'm trying to find this in here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And Denise, just a few minutes before we have to go to public comment.

Denise Webb – Individual – Chair
Okay. It's on page –

John Travis – Cerner – SME
I've got a bit of an answer here to your prior question.

Denise Webb – Individual – Chair
Okay. Let's do that. And then I can find my page, which we can do after public comment.

John Travis – Cerner – SME
So, the word I get back is Argonaut is not planning to have another implementation guide based on FHIR R4 per se, but that FHIR U.S. Core will include or cover Argonaut. HL7 will ballot HL7 FHIR U.S. Core. Argonaut may develop additional guidance, which then could be included in the next version of the U.S. Core. So, it's a feeder, but it gets covered by virtue of the process of FHIR U.S. Core including and covering Argonaut.

Leslie Lenert – Medical University of South Carolina – Member
It should never be specified in a regulation as the standard.

Denise Webb – Individual – Chair
Yeah. So, based on that –

John Travis – Cerner – SME
His comment was don't have them agree to adoption of something like Argonaut on FHIR R4 that doesn't exist and it wouldn't go through the ballot.

Leslie Lenert – Medical University of South Carolina – Member
It has to be the HL7 standard.

John Travis – Cerner – SME
Right.

Denise Webb – Individual – Chair
Good. So, based on that, this sounds like a sound recommendation that Ken is proposing.

Leslie Lenert – Medical University of South Carolina – Member
Oh, yeah.

Denise Webb – Individual – Chair
Is everybody good with it? We'll add that in then. So, for APIs 170.315 G7 through G9, which is existing regulatory tax related to APIs, is what the six months is referring to. That they need to have their documentation updated and published within six months. But for the new 10 for FHIR API and 11, which is consent management API, that documentation wouldn't be required until the 24 months. So, we're just going to suggest they add the words "these criteria" at the end of the sentence when I find it. And I'll type that into the document so you all can see where I am talking about.

Kate, I can't find the page. There's a page that references documentation for APIs being due in six months. If you can find it, let me know. Public comment, let's go ahead.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thanks, Denise. Operator, can you please open the line?

Operator
Yes, thank you. If you would like to make a public comment please press star one on your telephone keypad and a confirmation tone will indicate your line is in the queue. You may press star two if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thanks. And Denise, we will have to break right at 1:00 because we have another information blocking task force call that's going to start. So, just as a heads up as we wrap up the last ten minutes. And then operator, do we have any comments in the queue?

Operator
No comments in the queue.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. I'll hand it back to Denise and Raj.

Denise Webb – Individual – Chair
Okay. I was going to suggest that we probably – if you all have another call at 1:00, whatever we don't finish going over today would be the agenda for tomorrow. So, I don't know if we need to do a debrief or if you want to just cancel that?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yeah. I'm fine with canceling that. Kate, does that work for you?

Kate Tipping – Office of the National Coordinator – Staff Lead
Yeah, that's fine with me.

Raj Ratwani – MedStar Health – Chair
Yeah. I think that's a good idea.

Denise Webb – Individual – Chair
So, I did find the page on page 240 that talks about the documentation requirements for APIs. "We propose to establish a compliance date of six months from the final rule's effective date to revise their existing API documentation to come into compliance with the final rule." And we should suggest at the end here "for these criteria" and it's not all the API criteria, just seven, eight, and nine. Do you see that? Scroll down a little. Let's see. Page 240. Oh, here they are. Okay. So, down here where it says, "With the final – to come into compliance with the final rule", there were like three of us on the task force that read into that. Would the final rule include all APIs?

So, we thought that meant all the documentation had to be done. And talking to Steve, he said, "No. It's just those three criteria that you have to update the documentation within six months." If you all think that's clear, we could just drop this recommendation or we could just have them add it at the end of that sentence. We would recommend saying, "for these criteria" since they're talking about seven, eight, and nine.

John Travis – Cerner – SME
That would – I think that's a simple thing that shouldn't hurt for clarity.

Denise Webb – Individual – Chair
Yeah. It just goes to show how some people read things differently. I mean, read that like three times, and I thought – and we all talked about that. How can you have the documentation out there for the APIs when you get 24 months to get them delivered, right, and used? So, I was like, okay.

Leslie Lenert – Medical University of South Carolina – Member
A big waterfall.

Denise Webb – Individual – Chair
Yeah. Okay. So, that takes care of that one. We're almost to the end of our notes here that I have from the HITAC. All right. And there was a discussion around the ERX. Steve Posnack has actually asked for

some specific examples of where we would think parts of the ERX criteria – where we specify it's optional.

[Crosstalk]

John Travis – Cerner – SME
I've actually got another idea. And we are trying to get some substance to it, but I think that this is true, at least for the pharmacy transfer. So, then – I've actually got a different suggestion here. And we may need to talk about this further. So, what it sounds like, and we're trying –

[Crosstalk]

John Travis – Cerner – SME
Yeah. So, here's the idea. I think I am hearing that there are some of the transactions that are optional because they – well, I may not put that tag on it. There are some of the transactions that are focused on pharmacy operations. So, the pharmacy has not, I think, by and large, been a type of IT that has been subjected to certification. And if that is true, then there really is a big problem for an eligible clinician adopting this capability. They don't run a pharmacy in a physician practice. And you'd be making them adopt capabilities that have no relevance to them. It would probably work better actually as a distinct criterion if that is true.

So, we're trying to get to the bottom of that in our own review. The other part of this is that there is some that may be very much focused on long-term care. Kind of the same idea. So, there's almost like an over the amalgamation of the requirement here that one criterion doesn't do service to. If those things are true, that really some of these are subsets would be attractive to a given venue, like say pharmacy. And so, I don't think it works really well to have those optional under the same criteria, because ONC's possession policy gets in the way of that. And if you're not familiar with that that basically says that for you to make use of an EHR module you can't make – you can't have possession of it in part. You have to have possession of it in full and that at least requires legal licensure.

It may not require implementation, but it does require a legal license. And that's probably a bit problematic for a lot of provider organizations and certainly for vendors. So, I think there is a core of B-11 that can be required for the intended traditional purpose, if you will, of a prescriber-oriented scope. And then everything else should either be carved out as a distinct criterion – that would be my preference than seeing it as optional under the same criteria.

Denise Webb – Individual – Chair
Okay. And I think, getting at your point, we tried to, in 11-I, establish that this should be applicable for transactions relevant to their particular domain.

John Travis – Cerner – SME
Yeah. I think that's –

[Crosstalk]

Denise Webb – Individual – Chair
So, this is going to probably need a lot more discussion. And I know Sasha contributed quite a bit on this too. And I believe she'll be back next week. So, maybe we can – if you could bring back further

information to the task force and we could defer finalizing this recommendation on the call next week that would be good.

John Travis – Cerner – SME
Yeah. We'll try to develop that a little further. Right now, we're kind of trying to parse them apart and make sure we are understanding that correctly. But yes.

Denise Webb – Individual – Chair
Let's see. How are we on time? If we could go back just for a quick minute to recommendation 22? In my dialogue with some of the CIOs on this whole idea of app registration and our recommendations here, they illustrated an example. And I just want to see what you all think about this. You could have a health IT vendor or developer that their app, that their entity is verified and validated so that they can connect their app to, let's say, your EHR platform, John, through Cerner. But then let's say one of the developers gets fi—let's say a developer gets fired and has the keys to connect. What's to prevent that developer from connecting and downloading bulk data?

And this got way technical. And I was trying to think this through. But there seems to be real concerns about not having some vetting of apps. And maybe the discussion is around security more than it is about vetting an app. I mean, because it can –

[Crosstalk]

John Travis – Cerner – SME
That's interesting. So, are we speaki—I guess the clarifying question there is are we speaking of a user as an individual or are we speaking as an app developer as an individual or entity who was in good grace and – I guess what do you mean by got fired? So, a user who was an API user, an individual, at a provider can get fired. And usually, that terminates, under normal course, access rights that would enable them to use the technology that they'd use for access. If I'm an app developer out there and wind up with a relationship being terminated – so, I built something for and EHR launch use case, because that's where the bulk data would probably show up.

And I lose – you know, I was doing population health work for, you know, pick on Rush for MedStar. And for some reason, MedStar had an agreement with me to do that development work and I was going to provide an application to them to make use of bulk data acquisition using the API services. And I had my working relationship to them terminated, whatever degree of formality it was – a contract, an employment arrangement, outsourcing. So, after that, you're saying there's a concern that I, as the –

[Crosstalk]

Denise Webb – Individual – Chair
They'll have the keys.

John Travis – Cerner – SME
You're asking –

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer

So sorry. We do have to cut the conversation. I do apologize. We have to start another task force call.

Denise Webb – Individual – Chair
Not a problem. Let's continue this discussion, because I think some of this is just understanding how things technically work. Because around recommendation 22, there was some real concern. Okay. We can take that up tomorrow. And Raj, will you be on tomorrow?

Raj Ratwani – MedStar Health – Chair
I think so. I had to do a little bit of shuffling today. I'm hoping I'll be on tomorrow.

Denise Webb – Individual – Chair
Okay. All right. And if not, I should be able to handle it and then I have a flight to catch, I think, right after that. So, okay. All right. Well, good day, everybody.

[Crosstalk]

[End of Audio]

Duration: 53 minutes