Meeting Name	HITSP Advisors to the CCHIT-HITSP Joint Working Group Meeting
Meeting Date and Time:	February 16th, 2007 3:00PM – 5:00PM ET
Location:	Teleconference
Objectives:	HITSP Advisors to the CCHIT-HITSP JWG
Next Meeting Scheduled:	March 14th at 3:00pm Dial-in: 800-446-1162 Passcode: 751900

Agenda

General Announcements/Topics

- Lab Roadmap: next steps
- HITSP/CCHIT Schedule harmonization
- HITSP liaisons to SDOs for CCHIT concerns
- Engaging community in discussions on testing of repository functions of EHR
- Engaging with appropriate CLIA regulatory reps to ensure that for Use Case, the IS can enable CLIA compliance
- Alignment with AHIC - Providing input to AHIC/ONC on priorities for 2007-2008 use cases, Gaps in available standards for certification: options for addressing, Priorities for HITSP statements of work other than 2006-2007 AHIC use cases
- Tools Availability and Development / Conformance Testing Tools - Alignment of CCHIT & HITSP testing efforts
- Topics to bring forward at the next CCHIT JWG meeting

Decisions and Actions

Opening of Meeting & discussion on interoperability requirements

Peter Elkin started the meeting until Jamie became available. Peter started the discussion with a question about the future goals of the JWG. The question was if the JWG between CCHIT and HITSP should be recommending goals in terms of levels of interoperability that HITSP and SDO's should aim for in the next certification cycle besides aligning the HITSP and CCHIT schedules of workflow. In thinking about what the next work products for the JWG should be, perhaps the JWG should look to informing standards development committee about the needs in the industry that are not yet met. This would be a change to the paradigm where standards are ready, brought into HITSP, used to create Interoperability Specification's and then finally drive interoperability. Groups like HITSP should be recommending work that needs to be done and then responding to industry needs.

The concern is that if HITSP is creating interoperability specs, who is creating testable conformance criteria by which CCHIT certification can be established for systems claiming to conform to HITSP Interoperability Specification's. One way is to drive both directions – in addition to being a passive acceptor of standards that enable interoperability, HITSP also needs to be the driver by recognizing where there are demands for higher quality in marketplace.

The discussion continued with a question about the criteria to use to set a baseline to use. If the discussion is on raising the level, how does HITSP know what the current level is and where to take it?
In the Population Health working group, they have developed a beginning set of criteria to grade the level of interoperability of a given standard. Their plan is to vet this criteria at the workgroup, and then bring to the full Technical Committee, then to HITSP leadership, Foundations and other Technical Committee's,

to get consensus. Then it can be used as a measurement tool internally for HITSP's work, and externally for others to evaluate the certification process. Peter offered to share the documents posted to the Population Health Technical Committee site.

A comment was made that there should not be an expectation for CCHIT to have an active liaison with the SDO's. It is much preferred for the liaison relative to ONC to come through HITSP. If CCHIT has identified gaps, there has to be an effective way of getting the information through HITSP as the consolidator and liaison through to SDO's who should be addressing those gaps. There is a process that needs to be refined.

Steve mentioned that he has been following the Population Health semantic interoperability discussion and has concerns that the discussion is going off into an academic direction where there is more of a practical need that HITSP needs to approach in the near term (next 2 yrs). Would like to see a directional paper that defines what HITSP will be achieving in practical semantic interoperability next year and beyond from a JWG perspective. One of the main concerns that CCHIT has is how do you test interoperability?

Peter's response was that if you use the scale that his group validated and submitted to Medinfo, looking at semantic interoperability and some of the major standards used in our field, you can take scale and assign a value to each of the standards used in the Interoperability Specifications we have and tells you of semantic, syntactic interoperability.

Glen made the point that it is important to be careful about scoping of the use cases. If you get a scoping at the clinical workflow level, e.g. order entry, CPOE type of entry – order and results, and you want to achieve a certain level of interoperability and privacy protection, you'll wind up with a broad specification. Recommendation is for HITSP to rely on certain experts working within SDO's for their expertise to formulate the scope of the use cases.

Jamie wanted to get input from the participants about what the panel members would like the JWG to cover. He specifically wanted to get feedback about:

1. Harmonization of timeline/schedules
2. Next steps for the lab roadmap – transfer of ELINCS to hl7 may have impact on that. Is there an effective way for the ELINCS specification to reach the functionality workgroup in CCHIT through HITSP? What is the path through there and how do we expedite that without taking 3 years?

Discussion on next steps for lab roadmap

Steve provided a briefing on what was in progress for ELINCS. HL7 will be receiving from the California Healthcare Foundation ELINCS group their version of the ELINCS document as an HL7 v.2.5.1. specification. Most likely, this will happen in the latter part of next week – Thursday tentatively. They have submitted an intent to ballot this cycle. That ballot was contingent on getting a document by Monday. Based on what they discussed and when they have to get the document to HL7 for publication, they don't think they're going to be balloting this cycle.

So they will do the ballot as an informational ballot. If they do the ballot in the fall, it will be done in one cycle. Since HITSP has to get to ONC by Oct 12th, balloting in fall is cutting it close, but there is a chance that it can be done.

The impact from the HITSP perspective is that the Technical Committee can anticipate selecting the unballoted HL7 implementation guide and publishing the Interoperability Specification on that basis for the v.2.0 specification in June. This is going to have to be contingent on ELINCS passing the fall ballot. Since it's informative and not normative and what is in question is just the implementation guide, HITSP can get around that. From HITSP's perspective, the question for the JWG is if the HITSP Interoperability Specification is based on an unballoted implementation guide, what impact if any does it have on the CCHIT criteria for 2008?

The thought is that this question should be raised to the commission because the goal is to use standards from CCHIT. There is also a question of timing. It's important for the members of this workgroup to act as process facilitators. Since each one of the members of the workgroup has memberships in various committees and commissions, members can oversee the transition from one body to another and knowing that there is a possibility of slips in the timing, process or rules, can try to manage the process and planning to help the process along and avoid delays and inefficiencies. This way, tight timelines can be managed successfully; otherwise, the tight timelines may hurt HITSP.

In addition to that, another of the workgroup responsibilities is to make sure that nothing slips into these specifications to derail the timeline. There is a concern that with the way things are developing for ELINCS, what is going to come as an implementation guide will be highly constrained. This is being done for the implementation guide for the US in ambulatory, lab result exchange with the full intent that there needs to be other implementation guides to come out in future. There is a disconnect with what CCHIT is expecting. What we're being handed by ELINCS is a constrained implementation guide. So if we tried to change constraints of implementation guide to make it more general in this round – it will not work.

CCHIT is going to be expecting something that supports CPOE in an acute care setting. So there is a need to formally inform CCHIT that they're not getting what they're expecting. That's not bothering CCHIT because testing criteria for 2007/2008 is ambulatory. The point was made that there needs to be a formal way to share information with the various stakeholders. There are a number of informal liaisons who are passing information back and forth; however the information needs to be conveyed in a more formal way. This is the one of the objectives of the JWG; however the specific method has not been discussed. There is a need to create appropriate statements for the communication of these issues to CCHIT from the JWG coming from HITSP. The JWG does not make decisions but can make recommendations on more formal communications of these issues. This point will be presented at the JWG meeting next week.

Testing

The discussion moved to the testing of selected vocabularies included in the Lab Roadmap for 2008. In 2008, there will be an expanded LOINC vocabulary because the new ELINCS specification will try to cover the top 95% ordered tests, which was the LOINC list. CCHIT is not trying to introduce testing of SNOMED in 2008. This is all consistent with the current Lab Roadmap. The focus needs to be on expansion into microbiology which is scheduled for 2009. Currently, the ELINCS document is not available, so there is no knowledge of what it looks like. If v2.x messages are still being used, CCHIT will evaluate, but the general thought is to move away from v2.x messaging. Another issue is that a full test of interoperability for lab messaging cannot be done until the cycle is closed for lab orders. If you don't have a complete cycle occurring electronically, one side has to fake something.

Discussion on HITSP and CCHIT schedule alignment

Most of CCHIT participants are looking for a minimum of 1year between the availability of implementation guidance and the testing cycle based on associated criteria. However from the HITSP

board meeting, Dr. Loonsk, and also from vendors, the amount of time needed depends on the specific items. Some only need 3 months, while others need 12. There may be some greater flexibility in the timing of some of the criteria. It should not necessarily be a fixed rule that implementation guidance has to be available a minimum of 12 months in advance.

Glen pointed out that this does not necessarily mean that from CCHIT's perspective, the publication of the v2.0 Interoperability Specification from HITSP may have some additional flexibility. The thought is that the CCHIT vendors feel comfortable with the general guideline being a year. It is not so much about the work being done. It's about scheduling the work into the workstream without distracting others schedules. This item requires 1 years worth of work from the testing standpoint. From the experience of conducting the pilot testing of rudimentary testing results, there are a lot of hidden issues which will not allow you to take an implementation guide in September and have it implemented by December. It is not clear that CCHIT can figure out how to test an Interoperability Specification in that short period of time.

Guidance/Testing
The question of what kind of guidance is expected from HITSP and CCHIT to ensure testing matches the intent of the Interoperability Specification was brought up. This, Steve thought, was dependent on how much testing CCHIT needs to do for an Interoperability Specification. This leads to the discussion on semantic interoperability. To do an exhaustive test of the complete specification is almost prohibitive. At the minimum, CCHIT has to test a successful case, and a failure case for each one of the fields. That gets to be very tedious. This question of how much testing is needed for an Interoperability Specification before it meets the criteria to be put to use has been raised at CCHIT, and is now being raised at HITSP. Peter stated that he'd talked with people who worked on the v2 certification and there are some programs available to test basic v2 conformance at diff v2.0 levels. This means there are conformance criteria so can the currently existing processes and tools be built onto, instead of starting from scratch, to make the process as easy as possible? Lyle pointed out that there are 3 levels of testing needed:

1. Useability Testing
2. Interoperability Testing (this is the test that CCHIT would use to state if a product can be plugged into a NHIN
3. Benchmarking (to see what the maximum capacity of a system is). There would have to be a definition of the minimum level of response, etc.

The closest thing to this currently is IHE tests where they have alpha tests – test harness that can be used by individual products and the connectathon where a lot of vendors get together and test products together. These are grueling tests, and by the end of the week, it is clear which product is interoperable and which aren't. This requires great coordination to do successfully.

Steve made a point that the CCHIT model is not built on rigorous testing currently. Is the thought that CCHIT should consider building their model on that? The answer was that this is what the JWG is for. Now, HITSP can advise the JWG about the need for interoperability testing and CCHIT can evaluate their business model to support the development of a test-bed like the one described above. This question being asked does need to be taken to the CCHIT commission since they provide guidance on the intensity of testing conducted. The final consideration was that if testing tools were available at CCHIT, vendors will ask for access for developmental purposes. Similar to what Health Infoway is doing currently.

Discussion on next topics for JWG

It was decided that the following discussion need to be taken to the JWG:

1. Discussion on interoperability testing – the broad topic of interoperability testing with respect to the appropriate model, test-bed, platform, who pays for it, and what is the roadmap for it

a) What should the level of intensity be?
b) Actual tests
c) Actual documentation
d) Assignment of certain things to lower level components. For example, if a specific application depends on TCP/IP infrastructure assigned by the underlying operating system, it needs to be documented that the assignment was made appropriately. There is going to be lot of documentation and assignment in the 1st year.

2) Where does the PHR/EHR interoperability fall in the overall roadmap? To the extent that HITSP has published implementation guidance for PHR components specified by AHIC, what are the plans for CCHIT to put ambulatory EHR interoperability testing on the roadmap? This area has already been discussed, and it is not necessary that HITSP would work on it immediately. However, there needs to be a discussion into when this work should begin. There is also a need to have a plan on how to do what is being described, and a response to the industry.
3) Discussion into having the JWG generate interoperability requirements for future cycles. Meaning creating a roadmap for tightening the level of interoperability, and closing the loop between CCHIT, HITSP and SDO's. HITSP can play liaison role on behalf of CCHIT and HITSP jointly.
4) Confirm understanding on CLIA conformance. The suggestion is that the JWG should make a recommendation to the boards of both CCHIT and HITSP confirming that there is no plan to specify a mechanism for CLIA conformance at CCHIT. CLIA conformance is the obligation of the receiving lab
5) Discuss the idea of having joint meetings of the relevant co-chairs of AHIC workgroups, CCHIT and HITSP to ensure strategic alignment between and amongst relevant activities. This is a specific idea brought forward by the HITSP Panel members.
6) With respect to Lab messaging, discussions have been carried out for the v2 part of the specification; however, there have been no discussions yet on the CDA part of the specification. So the next step will be further developing and seeking to develop cross-affinity domain solutions for a lab report. This is something to have on the roadmap for CCHIT.
7) What is formal process/documentation for communication of important statuses or decisions between the groups involved (HITSP to CCHIT, CCHIT to HITSP, HITSP/CCHIT to SDO's)?

The discussion then turned to the need for a new discussion on historical results. This came up several times and Dr. Loonsk has mentioned it in some meetings. There is a prohibition on using historical medical results. This can be done from the JWG perspective, but it is likely that it will fall back to HITSP's domain. It is necessary to provide a clear differentiation between historical lab results and the retransmission of lab results sometime after the lab was done. That way, there will be more acceptance of using the document format and repositories for true historical results. Most "historical lab results" are not historical. They are re-transmissios because that is easier to do. Jamie thought it was reasonable to add this clarification to the v2.0 specification this year. So this can be clarified at the March face-to-face meeting.

Participants

Attendee, Project Role	*Org.*	*Present*
Robert Barker	NextGen	
Chris Carr	RSNA	
Howard Clark	DICOM	X
Michelle Deane	ANSI	
Gary Dickinson	CentrifyHealth	X
Peter Elkin	Mayo Clinic	X

Attendee, Project Role	***Org.***	***Present***
Louise Goler-Brittain	Booz Allen	X
Joseph Holtschlag	MassPRO	
Jamie Ferguson	Kaiser Permanente	X
Gwen Lohse	CAQH	
Kathleen Mahan	SureScripts	
Glenn Marshall	Siemens	X
Don Mon	AHIMA	X
Charles Parisot	GE Healthcare	
Sarah Quaynor	GSI Health	X
Rick Reeves	CPSI	
Maria Rudolph	American College of Cardiology	
Dan Soule	Cerner	X
Steve Steindel	CDC	X
Lyle Schofield	CodeRyte	X