



HIT Standards Committee Interoperability Standards Advisory Task Force Final Transcript July 16, 2015

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Interoperability Standards Advisory Task Force. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Robert Cothren?

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Rim. Kim Nolen?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Hey Michelle, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Kim. Anne LeMaistre?

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

Present.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Anne. Arien Malec? Calvin Beebe? Christopher Hills?

Christopher J. Hills – DoD/VA Interagency Program Office

Hey Michelle, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi. Eric Heflin?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

Present.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Eric. Janet Campbell?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Janet. Lee Jones?

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Lee. Lisa Gallagher?

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

(Indiscernible)

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Lisa. Paul Merrywell?

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Paul. And Pete Palmer? And from ONC do we have Brett Andriesen?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Brett's here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Brett. And is Nona on the line as well?

Nona Hall, BSN – Chief, Standards Adoption Monitoring & Reporting Division – DoD/VA Interagency Program Office

I am.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Nona. Anyone else from ONC on the line?

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Rose-Marie's on.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Rose-Marie.

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Hi, Michelle.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Okay, with that I'll turn it to you Kim and Rim.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you and welcome to our third meeting of the Interoperability Standards Advisory Task Force. We have a pretty full agenda today. There are a few things at the beginning of the agenda that we want to review quickly and then we'll move on to Section 1 comments. Just before we get started here, are there any changes or additions to the agenda? If not, let's go on to the principles, excuse me, I don't believe that there are any introductions that we need to make today; I think that everybody has had a chance to introduce themselves to the task force so, unless there are any requests there, I think we'll just go ahead and move on with the agenda.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

By the way, this is Arien here. And just want to let you know that I joined and I can only stay for a little bit because I've got some vacation that I'm on.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you for joining us, Arien. So today is our third meeting; taking a quick look at our timeline through our next few meetings, today's primary topic is the Section 1 comments on vocabulary, code set and terminology standards. Go on to the next slide. Just a quick reminder, we had agreed at our first meeting that we would revisit guiding principles of the task force here at each one of our meetings. Thanks to Kim for giving us an update following our discussion last week. Rather than read through these, I'm just going to pause here for a minute and see if there's

anybody that has any of these principles they want to discuss or any comments or changes that they'd like to re...suggest? There are a couple of additions here since our slides last time.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Rim, on number 2, bullet 2 and 3 are new from the discussion that was from last week, if people want to look and then we just added some extra words in the first one, the preconditions and dependencies.

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

This is Anne; it seems to match our discussion last time.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. Well then if there aren't any other comments or additions, let's go ahead and proceed. Kim also put together some notes from our last discussion just very briefly some of the things that we believe that we discussed and perhaps made some decisions on. We wanted to capture these and give everyone a chance to review at least some of the high level topics from last time. Again, I'm not going to read through these; they were distributed this morning, I don't know if people have had a chance to read through them, so I'll give people a second now.

And I don't think that we necessarily need to wordsmith these, but I want to make sure that there aren't any major points here that either were missed or really misstated. Kim, since you put these together, is there anything in particular you think you want to point out?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Arien, if you could look at bullet 3, because that kind of came from part of your discussion and Rim and I think Eric and I wordsmithed it the best that I could, but I'm not sure if I captured it as well as it could be.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I apologize; I'm in a car right now. Maybe I can look at it offline and provide some comments back?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Okay, that would be great and thank you for joining; I know you're...

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yup. No problem. Thanks.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Hearing nothing, why don't we proceed on to the next slide; this is some additional points and comments.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

So for the update, the first bullet I think was captured from one of Eric's comments, and I'm going on memory so forgive me if I get the wrong person. And then there was a lot of discussion about the stability of the standard and how to capture that and how it may vary from deployment to deployment, so, we tried to capture that there. And then for the scope, there was some discussion about the use case layer needed to be towards the beginning and then the

column for each use case should go to the right with the format. There should be a cross-walk between the use case and functionalities to...and explore the ability to tie functionality to the use case. There was quite a bit of discussion what should come first, the use case or the functionality and how to tie those together. We'll update this bullet after we get the update from Lisa today with the security standards that they had presented. And we felt like the ISA folks should point to all preconditions and dependencies needed to facilitate interoperability or it should have a disclaimer that not all the constraints have been defined under the scope.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

So this is Eric and I reviewed these earlier this morning when they were sent out and I believe they're a very good reflection of the conversation and I appreciate the reflection of those in this work product.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thanks, Eric. If there are no other comments, then thanks Kim for putting this together...

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

Hey, Rim?

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Yes.

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

This is Anne. Just kind of a question for the group on the very first bullet on security standards; I think what's there is accurate but I also thought I heard a process to be able to update standards as needed if we had a compromise. And I think that piece is missing from this.

W

Isn't it the first bullet? Or that's I guess raising awareness around updating...

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

Yeah, to me there's a difference between raising awareness, but I think there's actually challenging the standard...

W

Got it.

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

...if it needs to be updated, right?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

This is Eric, perhaps that could be wordsmithed and I agree and I think I perhaps was part of that conversation. And the point I was trying to mention there, which maybe we can do this

offline rather than taking the whole workgroup's time; but is that sometimes standards have to change overnight in reaction to a dynamic security environment, for example something which is secure today may be found to have a vulnerability and I just wanted to indeed to have some type of a layer like that in standards work.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Right; thank you. This is our last slide on the summary; is there anything important that anyone recalls that weren't captured in the slides?

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

And if you think of something afterwards, just e-mail Rim and myself and we will try to work it in to what we have so far. We were trying...we're trying do this after each call so that when it comes to the presentation to the Standards Committee, we have a good summary of what the group discussed.

Eric Heflin – Chief Technology Officer – HealthWay, Inc.; Chief Technology Officer – Texas Health Services Authority

This is Eric and I think it's an excellent summary.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Thank you.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thanks Eric and thanks Kim for putting this together for us. Kim's going to, as she said, is going to be trying to take notes during today's meeting as well and summarize some of today's meetings output so we'll plan on doing this at the beginning of each one of our meetings also. Hopefully in the future we'll be able to get materials out a little bit earlier. I think we were all a little hammered yesterday with trying to get other...meeting other obligations as well and so materials went out later today than we had hoped for and so in the future hopefully people will have more of a chance to review these in advance of the meeting.

Why don't we go on to the next slide? In our last meeting there were a number of reports that were pointed out would be useful for the task force to have access to and review, that there was output from some of those efforts that would be useful here as well, rather than having to reinvent everything. Some of those materials were distributed to task force members over the last few days and Kim and I wanted to take a few minutes to review those very briefly at today's meeting for people that may not have had a chance to go through them in detail themselves. Kim, I think that you were going to go through the first one, here, is that...

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Yes, I'll be glad to do that. I'm just really going to try to do this in 5 minutes with the paper because on the last call it had mentioned that we should review some of these documents that have already been done to make sure that either we're aligned or following some of the work that has already been developed and not recreate the wheel. So I took the paper on as one of my tasks as one of the co-chairs and just took a couple of slides, I just kind of cut and paste some of the pictures so people could see it at a high level and Arien, I know you're driving and you were part of this task group, so if you have something to add, please jump in because this is my interpretation from it.

But what I took from the paper is that they developed this overarching criteria for standards readiness and classification and they came up with this criteria. And at the time, I think we also have to look at the timeframe and where we were in health IT at that time. This was publi...or it...the task group sent this to the Standards Committee I believe in 2012 and so this was more of a time where we needed to name standards and this is Kim's take from the conversations that I've heard on this ISA Task Force and then going back and reading this paper is this was really a time where we need to figure out how to name standards. And a lot of the conversation that I'm hearing now, we have these named standards, how can we make them work right with the tighter constraints versus looser constraints and getting a little more granular into the standards.

So they had five criteria with need, maturity of specifications, maturity of underlying technology, deployment, operational complexity and market adoption. And when I looked at these, I felt like these were all things that have been part of our discussions. We probably didn't qualify them quite the way they had qualified them so one thing that I noticed, we had the need in there, so that's sort of like the use case but one thing that I didn't see that we've added into this ISA is the ability of that standard to meet its goal, which I think is a really important piece of the puzzle. And also in the paper they said this is really to inform and not to quantify a standard.

And if we go to the next slide; for the maturity criteria, they had broken it down into three major categories, maturity of the specification, maturity of underlying technology components and market adoption. And then you can see under each one of those that they have attributes for each of those that should be considered when looking at the maturity of a standard. And again, I think there are things in here that we have talked about in our conversations like the stability of the standard, where we've gotten a little more granular in our conversation about how to make that standard the best standard to meet those goals.

And then the next one on the next slide was the adoption criteria, I believe...adoptability criteria and they had three criteria under there; ease of implementation and deployment, ease of operation and intellectual property. And again, these had certain attributes that should be looked at in the standard to see how adoptable that standard is.

And then the next slide; and this was something that came up on our last call, you know, how to define an emerging standard, a pilot standard and a national standard. So I was glad to see this in the paper and it gives us a definition and it may also...we may want to...this to be a qualifier in our information to define a standard because we had a lot of conversation about how do we handle standards that are emerging that's in a pilot versus national and maybe this is a way to classify them and there is a definition for that. And if you look at the little chart on the bottom, it kind of takes that maturity criteria and the adoptability criteria to show how an emerging standard leads up to a pilot to a national standard in the chart.

And a couple of things that I pulled from the paper that I felt were helpful, reflecting back on the conversations that we had is at the end they had stated that the standards should be based on a use case, but they also show that there was a need for different functionalities. And so I thought that was very interesting since we had had the conversation last week that we need to kind of be able to tie in the use case with the functionalities; so these were things that they had talked about also. They also had a piece on evaluating retirement or replacement of a standard and how new standards should be analyzed. So, it was more of a statement so I think some of the things that they had said we should be looking into, our group is doing that. So I felt really good after reading the article and the conversations that we had had and I'll open it up for discussion.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

Well Kim, this is Eric, thank you for doing this research, pulling together this information. I really saw this and thought this was actually an excellent body of work to help inform as a national level. The only thing I would suggest is perhaps that we take these principles, which I think these are all, again, really well thought out and applicable to our work and actually define a way to actually apply them. So for example, the classification slide it talks about the three categories and we're using pilot and national, but how would we actually, in practical terms, categorize a given say a vocabulary as one of these three standards? To me that leaves the question of, what are the assessment criteria to...essentially to categorize it accurately? But other than that, I think this is excellent work; thank you for pulling this together.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

And Kim, this is Arien; I think that was an excellent summary and really well summarizing a complex topic and fairly represents the discussion on the task force.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

And this is Janet Campbell; I definitely think that this is a good framework for measuring things. The one thing that I would caution us about is that even within an industry or within a certain class of stakeholders, there are sometimes disagreements about how widespread a particular practice is. That's one of the things that really stood out to me as I was reading these comments where a lot of people...where comments would say, oh all systems do it this way or most systems do it this way and I thought, well, you know, in my experience that's not the case at all. And so I think that as the ONC goes forward in creating the Standards Advisory and evaluating this criteria, making sure that they get the feedback of say not just, you know, two vendor representatives in this group, but more the...more than that for the EHR market and the same for HIEs and other infrastructural providers and healthcare providers.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Janet, this is Arien; I think that's super-important and the IATF in their standards maturity model is incredibly conservative in declaring something an Internet standard. They effectively wait until there is lots of usage across lots of different parties and lots of different independent implementations before they declare something kind of ironed out. And I do think it's a reflection of the overall immaturity of healthcare interoperability that sometimes, and I've been as guilty of this as anybody, sometimes we want something to be true and so we find examples that are existence proofs for some flavor of interoperability. But if you step back and apply the Internet test to it, you're still well back into pilot-land as opposed to; you know...you're generally in emerging or pilot-land as opposed to national standard-land. And again, I think it's a really helpful bias to assume something is pilot until proven otherwise.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Arien, this is Rim; would your recommendation be that ONC or we adopt that conservative approach or that we try to reflect a spectrum of maturity in place or of adoption in places where that exists?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

You now I think there was really good discussion in the last call about being open to emerging or pilot specifications, but being very clear about their status. So, I don't necessarily think we need to make sure that everything on the ISA is bullet-proof and ironclad. It is important,

though, that if something is on that list and it isn't at that level, that, to our previous point, we make that utterly and completely clear so that we're not driving expectations that we overall can't meet. I think there's a level of frustration that providers and provider organizations have about the state of interoperability that in my opinion is mismatched expectations relative to what current state actually is. And if we were clearer about what current state actually is, we could potentially address some of that mismatched expectation.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you.

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

This is Lee Jones; just so I understand. Is this taxonomy supplanting or, you know, in our discussion here, trying to supplant or augment the ISA concept of, for example best available? Because I guess the best available wording implied something to me about there's no real selection yet and there may be one in the future where there's something even better available, but for now do this. Whereas this doesn't seem to convey that kind of notion, it's more standard is selected and here it is and it's, you know, maturity scale. Is this augmenting that idea or is it supplanting that idea of like best available?

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Well Lee, this is Rim; I can at least give you my view of this. One of the things that we've talked about at some of our past meetings is that for a lot of these standards, it really isn't black and white and although we may be able to identify a best available, there are questions about how well it is adopted and how mature it is, etcetera. And that those might be...I would see them as augmenting our description of each one of the standards that although it may be best available, it may not meet all of the goals; it may not be well adopted, etcetera. Whereas some best available standards may be very well adopted and may be a very good match for goals. So I would see this as adding additional information to best available status.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I would agree. I think of it as augmenting as well and it's specifically...I don't think it's saying this is the best available, use this; it's saying, this is the best available, look here and think pretty hard before you go try and...something else and determine if it's right for your purpose.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

I think that there's also an ability, especially if what we do is we find standards that are best available but miss some important goals that they're trying to achieve. Well that is also sending a statement that there needs to be a replacement or an augmentation of this standard in some way because it's not meeting current goals. And so, you know, even though it may be best available, it is perhaps in some cases will be a pointer to, there needs to be work here because the best available isn't, you know, well adopted, very mature or meeting all of the goals.

Thanks Kim. Are there any other comments on this paper before we move on? Arien, I think that you were up next to give us a brief overview of the Architecture Services and API Workgroup recommendations. I know that you're in the car, are you able to do that?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Yeah, I'm able to do that; I'm actually stable...area right now. So, and Janet also was on the Architecture, Services and APIs workgroup so she can provide some color commentary as well. The task of the workgroup was to discuss and propose an overall architectural approach to standards and interoperability. We selected as our model for an architectural approach that's been successful at the level of large scale interoperability that's required for healthcare, we selected as our model the Internet.

We noted in that Internet model the existence of what's been termed the Internet hourglass, which is the notion that there are a core, as John Halamka would say, there is a parsimony of standards in the hourglass that themselves can be built on and drive wider scale interoperability. And we gave a number of examples ranging from the original IP hourglass to the more modern HTTP and HTML5 and exchange approaches like JSON and XML as examples of those kinds of hourglass effects. And showed examples of how those hourglasses, the sort of narrow waist of the hourglass, drives innovation by standardizing a core set of components that then drive a much broader ecosystem of applications and use cases on top of it.

We then looked at applicability of that model to healthcare and we came up with a couple of very...we thought to be very powerful notions. One, an obvious one is building on top of the Internet and building on top of the success patterns and success cases of the Internet and making sure that we're drawing from the broadest possible Internet oriented ecosystem.

The second major one is encapsulated in a notion of core composables and orchestration patterns and it's a little bit dense, but the notion of core composables is the basic notion that the healthcare domain is built up on top of some kind of primitives in terms of describing healthcare concepts. And that at least to, as the famous saying goes, at least to the 80% level, those primitives are generally more alike than they're different. There clearly are some kind of fractal notions here and you can go deep in any particular domain and drive out a lot of additions, but at the 80% level, there's some notion of some core concepts.

And we noted that many of the most successful healthcare standards, and in particular things like V2...HL7 V2 have done a good job of creating a set of building blocks that can be mixed and re-matched to create higher level constructs. So in the V2 example, you know I've got a PID segment for describing patient identifier information and I can reuse that across a wide variety of message types.

The second big notion is the orchestration pattern and this is the notion that there are certain patterns of activity that are fairly general that you can, if you've got good core composables and you've got good orchestrations, you can build a whole variety of use cases on top of. So, one of the notions that we had is that if you do a good job at the base level, there are a large number of use cases that are specializations of the work that you've already done as opposed to de novo work that require brand new standards.

And the best example that we gave of an orchestration pattern is the notion of a pluggable App, kind of most famously demoed in the SMART platform context and the FHIR-based work where if you do a good job of selecting the underlying core composables, in this case FHIR-based resources. And you do a good job of the security standards and describing how an application talks to an EHR; in some of the work, for example that we've done in the Argonaut Project, you can then build a whole variety of use cases on top of that basic pattern.

Our recommendations, which were adopted by the Standards Committee, were to embed this notion of core composables and orchestration patterns into the work of ONC and find...have a preference for interoperability approaches that build on top of core composables and orchestration patterns or help find new, more general core composables and orchestration patterns instead of finding a stove piped approach that solves a particular use case in terms of one set of building blocks that aren't themselves generalized.

So as an example again, there's a lot of interest in PDMP work to help identify drug-seeking behavior on the basis of PDMP databased, you could do that by creating a PDMP standard and asking EHR developers to implement it. And if they implement it and they've just done PDMP and then the next use case requires them to do basically all of the same work, you've got a cost per interface that's significant. If instead you focus on building the Argonaut-based, FHIR-based App model and you discovered that PDMP is a really good App, you can implement it on top of the work that you've already done, but you can also solve a whole other variety of use cases including interactive decision support and a whole wide variety.

So the general recommendation number 1 is, take into account this architectural notion of core composables and orchestration patterns. Number 2, when you have a use case, seek to implement that use case in terms of core composables and orchestration patterns. If you don't have a good core composable and orchestration pattern first, seek to find a more general construct that that use case is a specialization of.

And then we had some recommendations for some research activities in terms of additional orchestration patterns that we felt encapsulated a variety of interoperability efforts that are existent. The work is general, but I think very powerful and in many ways, much of the EHR and provider community is marching in full force, at least for the application interaction and orchestration pattern. Janet, anything that I've missed or have described poorly or is in need of your very good approach to explanation?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I think the only thing that I was thinking about with particular relevance to this group, and I wasn't on the last meeting so I'm not sure exactly how it came up, but the...sort of one of the principles that we talked about was that by restricting the variability among the building blocks that should be our watchword and that should be where we should focus on constraints, because if the building blocks are constrained, you can still organize them in ways that have a variety of different purposes.

It's an interesting thing to think about though when you look at some of the other feedback which is, well how can we consider what these particular standards should be without a use case? And so I think it's a little bit of a building...or a little bit of a tightrope to walk for this group, trying to balance that not completely dictating the flow of everything in the use case while still providing a small set of building blocks that everyone can implement that can have the biggest benefit.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Thank you for that; that's super useful.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. We're going to need to move on in the agenda before long but before we do that, are there any other thoughts about how we might apply this to our own activities here? Thanks

Arien and Janet for your comments on that. The other report that we wanted to touch on briefly was the Transport Security Workgroup recommendations; Lisa, are you going to be able to give us a quick overview of that?

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Yes, definitely. Michelle, are you able to bring up the slides that I provided or the document that I provided?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Altatum can try and bring it up.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Okay. So, yeah, there we go. The history of this is that with regard to the standards document, we were not, as a workgroup, asked...formally tasked to comment on the document and that was because there were no security standards mentioned in it. So we, Dixie Baker, who was the Chair and I talked with ONC about this and were referred to Steve Posnack. And Steve Posnack encouraged us to send to him information about how, why and what standards to consider for inclusion in the standards document that ONC published.

So we put together a list of standards and some background information and provided it directly to Steve Posnack and also given where we were on the timeline of public comments, I also included this in the HIMSS public comments. So what this represents is Dixie Baker and I taking a quick look at what security standards we thought could reasonably be included in the ONC document. This is a list of what we felt was the mettle of the criteria for mature standards that were just outlined and were...would be useful to include in the documents.

So for us on this task force, I feel this is something for the task force's consideration and that's really the background. And you can see the list provided on the screen and you were sent the document as well. So, Rim and Kim, I think that, you know, really that was my summary. I think when you look at the list it's pretty straightforward and I just wanted to make sure that I connected the dots to what we on the workgroup as Chair and Co-Chair had provided.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

So this is Eric; I'm not sure if now is an appropriate time for comments, so I'll just be extremely brief on this and say I think this really is a great example of where I think use cases can help drive technical requirements. For example, looking through this list one use case I have in mind is do we want to enable secure encryption of channels? And it seems like many of these standards enable that capability or functionality, if you will, instead of a use case. But if another desired goal is to enable say non-repudiation of origin or non-repudiation of clinical action or to enable access control decisions to be made on the part of the disclosing party, then I actually do not see that there's actually a direct mention of a standard that would potentially address those desirable objectives.

And so that's why I think that really the use case layer is helpful at least and I, notwithstanding Arien and Janet's comments, I think those are great remarks and I do agree with them, but I think there's really is a spectrum where we need to take into account the functionalities at the middle, the use cases at the top and then the building blocks at the lower level. Because then

we, for example, could assess this list and determine whether or not enabling disclosing party access control decision making based on say information conveyed during the transaction is actually something we're seeking to achieve or not. If not, then this list probably is sufficient. If so, then there's probably some other areas where we may want to touch on some metadata, for example.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

And this is Lisa; Eric, thank you for those excellent comments and I completely agree. I think we should do that analysis by use case and it really makes a lot of sense to me.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. Are there any other comments? Thanks, Eric. Well thanks for that review, Lisa. Why don't we go ahead and move on. We're a little bit behind our schedule, but there are a number of comments to Section 1 that we'd like to get at least a good start on today. Our current agenda and timeline calls for us to complete this section today; I don't know that we'll get through all of it, but we'll get through as much as we can.

What you should have received in slides was a summary of each of the sections of available vocabulary, code set and terminology standards and some of the public comments on each one. Unless there are other suggestions, I would suggest that we simply march through these and see if there are any comments, any thoughts about each one of the standards that's been proposed here in relation to the topic and anything in particular that needs to be added or commented on in the public comments here. Why don't we go on to I believe its slide 13 is our first standard in the group.

So in this case this was addressing allergy reactions, a proposed standard was SNOMED-CT and folks can see the public comments, the summary of public comments that were here; any thoughts on this standard for this purpose? Actually let me ask a different question; is this a reasonable way for us to proceed for the rest of the meeting today is to go through each one of these standards in turn and comment on them or does someone have a different suggestion on how we deal with the comments?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

It's as good as any.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Rim, this is Kim; I don't...I'm fine with that way but I do have a comment on this one.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Go ahead, Kim.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Um, well it says recommend grouping all allergies together and there are different types of substances that cause allergies; it could be medications, food, environmental, different things and I know for like medication allergies, I believe that's done by RxNorm. So I wasn't sure that the SNOMED-CT here and then grouping all allergies together, what they were meaning by that or...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well this is Clem; the other issue is whether they're talking about the allergic reaction that is hives, that sort of thing, which SNOMED would be right on or the thing to which is allergic. I think they're talking about the phenomenon that happened when they had the allergy, but I don't know.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

It was...at least in the comments, it seemed clear that agreed...that most people were in agreement that reaction should be coded to SNOMED-CT, while some people I think said free text, which I think is probably a pretty bad idea. I think the second part about recommending grouping all allergies together, Brett, correct me if I'm wrong, but that's not specific to reactions, right; even though this slide is titled reactions?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Correct. Yeah, so in general there was support in the comments for grouping allergy reactions, medication allergies, food, environmental allergies into kind of a single are in the ISA related to allergies and different standards could still be used to express those values, but in general, support for seeing those kind of all lumped into one area; that's right.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Which is really different though between grouping all of the allergies...types of allergies together in a single section or in a single concept within a larger interoperability structure versus where they're placed in the document; I got the idea that people wanted them together in the advisory. But that it did seem a little bit split about whether we should just have all terminology...all appropriate terminologies in a single section versus sort of separated food from environmental from medication.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I don't know what they described but our other committee thought these should be separated because it's just a different world, you know, food allergies you don't always know the...there's not an ingredient label on all foods. There's just a whole bunch of different problems with food allergies, except for maybe the big 9.

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

So, this is Mark Roche; I have a question. I'm looking at the latest version of Consolidated CDA and specifically terminologies. The slide that you have in front of you, general support for SNOMED-CT, is that SNOMED-CT for allergic reactions or allergen names?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Good question.

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

Okay, let me help you by giving you a little bit of a snapshot of what's currently the status. Currently allergic reactions are encoded...are required to be encoded not only in SNOMED, but a specific subset of SNOMED called the problem value set; it's a specific code of SNOMED.

SNOMED-CT contains about 400,000 terms; you don't necessarily want the allergic reactions to be recorded using SNOMED-CT code for micro-organisms or procedures. So for allergy reaction, we already have a mandate, not a recommendation, a mandate that a specific SNOMED-CT code be used.

When it comes to medications, you have actually a collection of different coding systems and there is actually a cascading principle that we adopted at HL7 for those instances. And so when it comes to allergies, I'm looking very quickly through Consolidated CDA as we talk; so for this allergies we have a value set called substance reactions and that value set must be used. And the cascade goes following: If you want to document an allergy to a specific drug, you must first use NDF-RT. If you don't find the drug in NDF-RT, then you use RxNorm. If you don't find it in RxNorm, then you use UNII. If you don't find UNII, then you use SNOMED-CT.

SNOMED-CT is used for substances other than clinical drug. For clinical drug it's NDF-RT from drug classes and RxNorm for clinical drug ingredients. And for ingredient identifier, which is the...for the investigational drugs for example, of course some other ingredients we use UNII. Keep in mind that whatever you...that typically information, and the reason why we did this cascading principle is because the information about allergies can flow in between different fields in electronic health records. So let's say you prescribe a medication to a patient; if the medica...if the patient experiences an allergy, you automatically want to put that allerg...medication as an allergen to the allergy list. And because we...in medications we require RxNorm, it was logical to facilitate the transfer of RxNorm codes to the allergy list. Now I'll stop, so, if you've got any questions.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That makes...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

So...go ahead. Sorry, I'll go ahead; this is Janet again. My thoughts on this, looking at that, the data here and also looking at what the comments were, there was...it seems like it was relatively split between whether we should try to have all allergies be similar but with that kind of flow down purpose where you have separate code sets for separate types of allergies versus actually separating them out more, not only in what code sets they use, but also in how they might appear in a document or how they are placed there.

My suggestion would be that it would probably be premature for us to say that, you know, that food allergies should be kept separate from drug allergies because if you don't already have that separation, it's a big change to put it in place where if you do already have that separation, it's not a big change to combine it together. I think it would be useful to maybe start to...and I don't know whether this belongs in the Standards Advisory or not, but to start to illustrate best practices.

For example, that you should be able to tell the difference between a food allergy and an environmental allergy as you are capturing it in your system so that you could separate it out in the future, if that became useful. And then also the comment and this also goes to what the previous speaker was saying that medication allergies really should be either at the ingredient or drug class level, someone had the comment that you can't really be allergic to aspirin 81 mg. And I think that's a really appropriate observation and so that anybody who does have a quick add to allergy list from the drug list, should be considering then getting around to having a conversion to make that particularly more generic.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thanks. Are there any other comments on this slide?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I just think this is a very complex space and I wouldn't make quick judgments. There...currently the big problem with food is there are not any easy codes for them available.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Do you think it would be useful, you mentioned the big food allergies and I think that there are...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

...a list that would be important.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

There are...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

If it...just

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

We have a list; there's a list is from the UNII; an example is peanuts. If you want to say peanut is a food component, you would use UNII. If you use...now, NDF-RT also has soybean oil, for example; so we already have identified the separate...we actually have 4 different value sets; one for drug classes, one for drug ingredients, the other one for like drug ingredients and food ingredients and the third one is a summative value set just like food ingredients and anything else you cannot find in the previous three. So we already have identified those 4 value sets.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well Mark...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

My point though was that if not constrained, UNII is a big kind of pain to use and SNOMED, when constrained, is...tends to, I think...again, this is a little bit opinion, I'm speaking from just the people that I've worked with, but it's simpler to grasp saying that someone's allergic to strawberries and how to find that within a constrained...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well there are a list of 9 that the American Allergy Association lists and I thought there was going to be...someone was going to gather them together and present them as a subset. But, I mean the problem...the difference between food and medicines, if you order ampic...amoxicillin,

you can tell what's in it if you order, you know, if someone eats a Snicker's bar, you've got to a lot more work to know what's in it or if they're eating soup at the restaurant so that they're just not parallel, regardless of what codes are available; knowing what's in them is hard. That's why I think we should think of them separately; whatever we finally do with them is different...would be different. And we should get that list of 9, the big ones, somewhere; I thought someone was doing that.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Hey Mark, this is Kim. You mentioned it's been defined but how is it being implemented?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I don't...yeah, that's...I don't know.

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

Well, it's been...well, it's part of the Consolidated CDA Release 2, so it's not...it hasn't currently been implemented in Release 1.1, which is Meaningful Use Stage 2, but in Meaningful Use Stage 3, what was...that was what was proposed as part of the Consolidated CDA. So whenever you produce a patient summary document, a patient note, a transfer of care note then you know, you provide a whole bunch of documents and if you put allergies in, there is a specific prescriptive way of how these allergies should be encoded and that was proposed in MU3.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Yeah, Mark?

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

So MU3...would probably...go ahead.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I think you're stu...what you describe is really good, but how does a physician or a nurse actually know what to look for in the menu when someone says they had chocolate syrup on...with a cherry on top? I mean, how do you actually get from what you can get from the patient to the code?

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

That's a good question. One of the things that I think it was mentioned in one of your slides previously is the consistency in implementation. And based on what I've seen so far, there is little guidance on, simply because we don't have much data from the field, on the...on what the users are actually doing and we're just now actually starting to get actual C-CDA examples. I'm working with Kim on getting even more of these examples so that we know what physicians are actually doing so that...we can then feedback...take that feedback and look at our...how the Consolidated CDA words the mandate. Currently it just says you have to use, you have to use these value sets, but it doesn't...we haven't really elaborated any specific use cases, for example. So that's a good question, Clem.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Well, and that was my point that if there...if there are ones that we know matter, then let's put that in the sort of advisory, the Standards Advisory, with the particular codes. My preference is for SNOMED, which I think echoes at least some of the commenters for food allergies, but there are probably more thoughts that could be taken into account. But I think the point is that if you advise developers to have at least a list of the big allergies that matter in the pick-list of the allergies that you can choose, that's better guidance than saying, kind of do UNII and we're going to do more research, you know.

Mark Roche, MD, MSMI – Vocabulary and Terminology Subject Matter Expert – Office of the National Coordinator for Health Information Technology

So, I'm going to put in the public comment the list of what's actually verbatim in the Consolidated CDA so that you can all have a look at it, how we've worded it so far.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thanks, this has been a really good discussion and I do...I would agree with several of the comments that this is a very complex area, you know, the slide was identifying allergy reactions. I think that we've also spent a fair amount of time talking about food allergies, which is covered on slide 18. If you want to bring that up real quickly and let's just make sure that there isn't anything on any of the comments there that we need to cover here as well. I think that most of what was summarized there has already been part of today's discussion.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

But the only thing I'd say is to make sure that we're distinguishing between putting food allergies with other allergy-related stuff in the Standards Advisory versus putting the food allergies in with medication allergies in a larger grouping of allergies because it seemed like the comments are kind of split on that.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Right, thank you. Why don't we go on to the next topic? If we go back to slide 14, the next one that was in our list was care team members; proposed standard was NPI. Obviously there were comments there about not...potentially not all team members can be described by an NPI. Are there thoughts on this standard?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I thought it was going to become very close to allowing that, including people like taxi drivers. So if anyone knows more than I, I thought there were plans to encompass everybody, I don't know where it stands now. Or maybe it's just people who billed against Medicare, but...

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

This is Eric; I completely agree with the comment that this identifier is not universally assigned to all care team members impacting the ability to use it. And I kind of go back again to the objective, you know, what's the objective for the exchange of identifier? Is it just to identify a physician or is it to identify all care team members and then for what purpose? One concrete example I think Arien mentioned briefly earlier is in PDMP systems, typically they're access control is such that they require the state board licensing number for the prescribing physician in

order to access the prescription drug monitoring information which means that there has to be some type of a mapping table.

And so my overall comment would be, let's first identify do we...is our intended function or use of this related to this capability to provide a globally valid identifier that can be assigned, curated and authoritatively managed for all care team members. And if so, then how do we address that issue? But in the absence of identifying really the objective we're trying to achieve, it's really difficult to assess or comment on the applicability of a given solution such as NPI.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Well, this is Janet and I would say that I definitely agree with that and I agree with the commenters that of course point out that other people play important roles on the care team and it would be useful to identify them as well. But I would argue that it's...in the absence of anything else, NPI seems like a candidate, and I would have made this statement a lot stronger except for that recent article that came out about how badly maintained and curated NPI was. And I was wondering for our ONC friends on the call if you happen to know of if there are any, I mean I know it's not your domain, but are there any efforts to correct that problem? Is NPI going to be better in the future or should we be really thinking about not even adopting it now and just building for something better?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I think the horse is out of the barn, it's been adopted, you've got to use it many circumstances. It's required by Medicare that I can give you the list, nurses, midwives, nurse anesthetists, dentists, denturists, chiropractors, it goes on and on, clinical social workers must have one. Other healthcare workers aren't required to, but housekeeping staff...well, I think anybody who wanted one could get one who's in the healthcare business. I mean, I don't know what all...I mean this is probably a 2 billion dollar task, you know, if you're going to start another one.

Veronica Gordon, RN – Program Analyst – Office of the National Coordinator for Health Information Technology

Hello, this is Veronica Gordon and I'm new to the group; I support Chris Muir and I'm a registered nurse. Registered nurses do not have NPIs, nurse practitioners and midwives, advanced clinical practice nurses have NPIs because they are considered providers, but not registered nurses. However, we are a very integral part of the care.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

But as I read the thing on the web, the providers you name must have one, but the other ones are not required to have one, but it sounded like they could get one.

Veronica Gordon, RN – Program Analyst – Office of the National Coordinator for Health Information Technology

And nurse practitioners, which is a nurse...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

(Indiscernible)

Veronica Gordon, RN – Program Analyst – Office of the National Coordinator for Health Information Technology

...but they are an advanced clinical practice nurse.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I'm saying that they're required to get one and the other...

Veronica Gordon, RN – Program Analyst – Office of the National Coordinator for Health Information Technology

Right.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...other healthcare industry workers are not required, but I think they can get them.

Veronica Gordon, RN – Program Analyst – Office of the National Coordinator for Health Information Technology

We have state licensure numbers, which are associated to us, but yeah, but there's...and there are some places that actually have group numbers, you know, for nurses like me out of...I have a Texas nursing license and so I have what is called a compact, so I can use that same number for Maryland and I think Virginia, a couple of other places, but that's not...it's not really a national provider identifier number, it's a nursing number.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

So it seems like, there does seem to be consensus on the call that there is a need for a nationally curated identifier that can be assigned or used and carefully created for each member of a care team, but...may be...

Rose-Marie Nsahlai – Office of the Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

This is Rose...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle; just a reminder to ONC staff, this call is for workgroup members so please let them speak first. Thank you.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thanks Michelle. Eric, you were saying...

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

Oh, I'm sorry, I didn't want to talk over anybody...and so I'm wondering if maybe we could leave this discussion topic as, the workgroup, if we have consensus, and I don't want to speak for the workgroup if we don't, but perhaps we could leave it that we have consensus that this is an area to investigate to see whether or not the NPI number could be...perhaps the program could be perhaps modified if, as necessary, to meet this criteria including authoritative curation, assignment to all care team members and so on. Thank you.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

I think that's a good idea, Eric and I was going to suggest to Brett that there were a couple of questions that have been raised by the task force members here that perhaps we could get some clarification on what is...what the requirements are and what the capabilities are for NPIs moving forward?

And I also think that Eric's suggestion early on in the discussion was a very good one is to define what the purpose here is, which also means that we need to settle on what...to what extent are we trying to codify the care team? Does that include, you know, housekeeping and taxi drivers? Does it include the nursing staff? I think that many would suggest perhaps the former is a no, but the latter is probably yes and if that is true; then there is clearly a gap here. So I think one of our challenges will be to define, what is the extent of the care team that we're trying to address?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Could I add one more follow up, my question about is NPI as flaw...how flawed is NPI and is the effort right now to fix it versus try something else? It sounds like fixing it makes more sense, but I have no idea what's going on with that or even if it's, you know, you can't read...believe everything you read in the paper, but it seems like it was an issue.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Right; I don't know if it's possible to get any information out of the NPES modernization program that might impact the task force's comments or deliberations here. It might be worth our while to look very quickly, over the next week.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yup, I will try to dig up some info, anything that I can share.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yup.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Why don't we move on to the next topic? I think there are some unanswered questions there with NPI, but I think that we probably should try to move on. Ethnicity was the next category and a proposed standard there, people can see the comments; need for more granularity, etcetera; comments on this standard?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

This is Eric; we spoke about this yesterday in the IHE body, talking about the de-identification of information for Office of...Finance which is simply using the OMB standards for race and

ethnicity and I think they, if I recall correctly, as mentioned there are 700 different entries in that table. And so I'm...if that's true, I'm not sure that I would support the need for more, more detailed information. But one gap that I think was identified is the fact that this apparently is difficult to use where you have an individual identifying with multiple races. This appears to be an area that's not currently anticipated by the OMB data set.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I think in the standards you can already put in more than one race.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. Are there any other comments here, anything...any actions we need to take? Why don't we move on to the next slide then which is encounter diagnosis, proposed code sets for SNOMED-CT and ICD-10 and there was a related question here concerning whether administrative standards should be removed.

Eric Heflin – Chief Technology Officer – HealthWay, Inc.; Chief Technology Officer – Texas Health Services Authority

Well I think it's a great question and really I don't know the answer because I think it kind of goes back to the issue and I will refrain from mentioning it again on today's call which is, what are we trying to accomplish by this...that which is...by the Standards Advisory. So if we're trying to accomplish use cases that include both clinical as well as administrative data sets one or the other or both together, then it seems like it would be...that would drive the answer to this question.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I would...CPT and ICD-10 and 9, I'd keep them; they're historical, they're useful, they're not as good as SNOMED, but they're not horrible.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I would add that one of the commenters made the points that at least in the US you are still required to code an encounter diagnosis using, you know, ICD-9 or 10, right? So for as long as we have to do that, it makes sense that we wouldn't have to ask providers to do both; so having...taking advantage of what is already required would be a good idea.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

You're not suggesting that ICD-9 or 10 be used exclusively though, are you?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

No.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

It's just part of the package.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Right. I want to come back to Eric's comment here for a second and Eric, I think that it's good that you kind of continue to bring this up. We talked about use cases a couple of times now and

that our deliberation along some of these standards ought to be driven by the use cases that we're trying to support, but we find ourselves somewhat in the absence of use cases, in trying to make these comments.

I know that that's not on our agenda today, but I wonder if we should pause here for just a few minutes and talk about in the absence of use cases, how should we proceed? Is there a source of use cases that we want to adopt to help guide our discussions as we move forward? Is there something, for instance, in the interoperability roadmap that might guide that or other sources of workgroup activities within the FACA bodies?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

Well that's actually a great question, I've been thinking about that as well and it seems like we can, to an extent, reverse engineer what we think are the intended use cases at a national level by indeed looking at MU regulations. Because they speak to essentially several use cases such as public health although there's obviously sub-use cases below that; transitions of care including sub-use cases such as hospital discharge versus referrals versus longitudinal or episodic and so on. So one way might be to use those and I think that's what I tend to mentally use to judge items like this is, what are the identified, not explicitly stated use cases in Meaningful Use.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

How do people feel about using Meaningful Use as a guide for the use cases, at least for our discussion over the next couple of weeks?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

I think it's a good starting point.

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

This is Anne; I agree.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

And I tend to...with that as well; I don't think that any of us would necessarily claim that it is comprehensive of everything that we could imagine, but it is going to be the concentration of a number of providers. It will mean that we may be focusing on provider interoperability as opposed to some of the other stakeholders, but that may be appropriate as well.

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

Yeah, I was going to ask if, and I haven't been thinking about Meaning...looking at Meaningful Use lately; this is Lee Jones. But, does that cover...do those kind of use cases cover some of these emerging models around community-based care for population health management and that sort of thing?

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Good question, Lee.

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

(Indiscernible)

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Brett, maybe we can take an action that between now and our next meeting that we would try to enumerate at least the use cases that are implied by Meaningful Use. I'd be more than happy to work with you on that and try to come up with a list and maybe we can rope Eric in, since he was brave enough to suggest that to maybe review what we've put together before we bring it to the task force next week.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

This is Eric, I'd be glad to contribute in any way to that.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. Thanks for indulging me a little bit on that sidebar; any other comments on encounter diagnosis? Why don't we move on to the next slide then, family hi...family health history.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well the only thing the...I mean, if no one else has a comment is that they're mixing apples and houses; SNOMED-CT is a vocabulary and the HL7 Version 3 genomics is a message structure so it's not quite an alt...it's not an alternative exactly.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. So is the recommendation here also that I think Brett enumerated on this slide to explore with partners in research community and other stakeholders. Is there anything that people are aware of that is happening in the industry...this topic or is this a new initiative that someone is suggesting to the comments?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

No SNOMEDs already required for family history as one mechanism of storing it in the message standards, as is the V3, I think in the NPRM the V3 standard; both are available.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

This is Kim; I feel like they're, in one of the comments they're trying to lean towards more genomic and genetic information that may come in from family health history versus...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

This may be another one that gets back to purpose.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Yeah, yeah.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Good point, good point. Any other comments on this?

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

I think...

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Let's move on, the next one...

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

...goes back to...

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

...I'm sorry, go ahead.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

I'm sorry. I think it kind of goes back to, what are we trying to accomplish here? For example, are we trying to provide information for a clinician to read in a narrative format in order to determine if, for example, a certain social condition is...represents a tendency for an individual to be susceptible to the same condition? Or are we trying to codify this so that we can actually do research on this for, you know, answers to the same question because those potentially have different requirements; one could be, uncodified... mapped text which is I believe what largely is used in practice today. And yet it would require some type of a value set and a vocabulary. It's like I would like to suggest that this provide...we ask for some clarity on this and perhaps next round we ask for more feedback from the community about what the intended purposes are for the capture of family health history information, if that makes sense to everybody.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

That makes a lot of sense.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thanks, Eric. Let's move on then; as I said, I think the next one was food allergies. I think that we've covered this topic so let's go on to the next one, excuse me, which was functioning and disability. The general question, should this pur...category be in this document; do we have a need for this? And there was at least some call for supporting this. Any thoughts? I'm not familiar with the International Classification of Functioning, Disability and Health; is it an appropriate standard to use here? Is anyone familiar with it?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I am. It's got...it's a very complicated thing; it's got 4 levels. The first level is what most people use. There's a lot of controversy; it's hard to use for some purposes. I wouldn't rush to it.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

The other related question around that occurs me, too...I too am unfamiliar with this standard is there a way to convey that in a value set and can they convey it in some type of a...summary or a message? And will CDA have a slot for it.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

No...well, it's been voted on some times and pushed out, pushed away; this has been discussed for about 5 years. The big issue is that the way that it's going is people are doing little survey instruments to find out disabilities, not just declaring a state. You know, if you look at the Medicare forms, they're...none of them have...they all have these questions that are like over ranges, a lot, a little, not too much.

Eric Heflin – Chief Technology Officer – HealtheWay, Inc.; Chief Technology Officer – Texas Health Services Authority

Right. Thank you.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

I don't think we can solve it on this call.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Is there a recommendation that you'd pass on to ONC? I think that your comments earlier about that the ICF standard is complicated and has been voted on a couple of times and continued to push away may be an important consideration.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well it's very political and it keeps getting pushed; I think WHO likes it. So I don't know what position to take except I wouldn't rush it.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

All right. Thank you. Let's move on to the next one then which is gender identity.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

So, this is Janet; this is one that we had a pretty strong opinion on, as did the Fenway Institute as did a couple of others. I think what really emerged for me in reading all of the comments though is that prior to being able to even start to talk about this, there's not a really strong shared understanding about the difference between sex and gender and the various reasons why you might want to record it in a medical record, as well as the difference between sexual orientation and who you have sex with, which are also two different things. I think that maybe my advice for this is that maybe it's time to start having the discussion at a national level, and I don't know who would convene that sort of thing, to really start to come to that shared understanding here.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

I think that's a good point.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well there are some well-identified pieces of it and there's progress been made in some of them. I don't know if everyone's happy with it but the big problem in the discussion is people are blending them all, as you've just mentioned, you know, the di...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Yeah.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Well is there a specific...one of the things that you mentioned there is you're not sure whose task it would be to convene such a discussion, but it does seem to me that perhaps a unified discussion is important. Is there a particular recommendation that we might make?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I think the Fenway Institute's approach or having...clearly defining the different fields or questions would help. I don't think...I think someone needs to just say what they think they are and then let people argue about them.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Yeah, and Fenway's close. They don't give the entire sort of, you know, complication of having to deal with downstream systems and the need for kind of a legal identity, but they've got the rest of it. I think though, my recommendation was going to be, I don't know if IOM has done any work in this area or how they sort of relate to a more governmental body; but this seems right up their alley.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well and the other dimensions, you can go down into cyto...into genetics in the cell, you know X Y is the simple one but it goes way on down, XX...you know, and there's divisions and duplications, all kinds of stuff in cytopathology that is yet another dimension that fractals forever.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

And also current organ inventory, which I haven't seen mentioned on any of these, but which is really what's more important in someone who's transitioning.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well maybe the Fenway thing could at least be distributed to the committee and then an IOM would be...might be a solution in the long run.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

The Fenway one's pretty good; it really is.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Can that be passed around?

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Brett, can we take an action to distribute that?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

We can.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Brett, do you know the report in question, I don't know if they actually linked it from their comments.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

I don't know if it's specifically linked; I know they pulled out some text from it, but I can do some digging and try to find out.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Okay; if you can't find it I think I've got it somewhere. This is Janet.

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Thanks, Janet.

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

Can I...so, is this meant to...it seems to me like the context may matter some in which you're trying to figure out what this is, you know, the gender identity. For example, if you're really trying to do some sort of medical treatment and it's important to understand, you know, biologically, anatomically and other ways what the person is different than if, or may be different than what the person may self-identify with or as and that may be important in another context such as, you know, a care plan where there are other services and things that may be available or applicable to a person based on that kind of classification. So does it...is there really a one-size fits all answer to this or...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

There's not and that's...

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

...is there room for...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

...there's not and that's clearly what the Fenway Institute's report gets into; there's what you identify as, what you were born as and what you...other systems need to recognize you as. And then, as was mentioned, too, there are variations of that which is which organs you have, which genes you have, etcetera.

LeRoy E. Jones, MS – Chief Executive Officer – GSI Health

Okay.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

The administrative identity is actually defined by what bathroom you use, I think, at least superficially...

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Uhh, not really. Nope.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

No? How do they...well they have a definition in HL...it's just 3.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Right, the administrative I think is what goes on your driver's license...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Oh, okay.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

...in many, but not all states. So...

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, you know the answers.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Let's see if we can get that report out so that people can review that.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

And I'll say there are things that are still missing in that report, in at least some of our customer's opinions; so, keep that in mind as well.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

If we have time, I'd like to try to consider immunizations real quick; I know that we're getting to the end of our time. Do we need to turn to public comment or can we try one more topic?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Try one more topic.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

I would agree, so let's go on to the next one which was historical immunizations. Are there comments on the standards selected here?

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well this is a complicated subject because this is something new, the NDC code and I think the key here is that if they do NDC code, they also have to be sure there's always a CDX code around because no one's going to know the NDC code, you know, it...when...after you leave the office.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

This is Kim; I'm not in favor of the NDC code because they're reused, there's not a group that manages them and so I don't think it's a good code to identify something.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well, I'm not for it but they defended that...CDC really wants this and are pushing really hard and they defended it saying they're not going to have that happen anymore. But you know how that sometimes works out.

Eric Heflin – Chief Technology Officer – HealthWay, Inc.; Chief Technology Officer – Texas Health Services Authority

So maybe that goes back to one of our first discussions today which is our guiding principles. Perhaps one guiding principle should be that we only recommend adoption of that which is a curated standard and we try to avoid the standards that were...that's defined as a standard, either vocabulary or other standard that's not maintained by anybody anymore.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well you can't list me as agreeing with Kim but I do.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Well, and I have a question here and maybe Janet or somebody in the EHR world can help us. How I understand immunizations being recorded in the EHR, it can happen in four or five different places and the historical immunization that i...that would be the history of somebody getting the immunization versus the administration of somebody getting the immunization or in the order entry the physician ordering the immunization or even in the e-Prescribing system, with somebody ordering it for it to be done at the pharmacy. So, I think it would be good to understand what they mean by historical; is it in that historical part of the EHR and Janet, I'm going to lean on you because you probably know the EHR the best and then we could help define that better.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Yeah, my understanding is that when they say historical what they mean is you ha...you don't have the information that you would have if you were putting the drug into the patient at this moment. So basically the patient comes in and says, oh I went to Walgreen's and I got a Pneumovax or whatever and they don't have any paperwork for it, you still want to record that, but you would never have the type of granularity to an NDC code, you may or may not have the granularity of an MVS code, but probably not. Where on the other hand, if you are actually...if you have the patient in your room right now and you're giving them the shot, you have the package and can enter that into the system and if that information is known, it's definitely good to provide it.

Whether you should actually separate them out into two purposes versus just provide the most accurate code that you know across the board, I kind of like the latter where you just throw in as many codes as possible and kind of let the other, you know, because more information is better than less.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well I was...

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

And I was...go ahead.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

...I think you've got to have a CDX code and in terms of the historical, and this is the ordering side of it, you know that physicians aren't going to know what NDC codes are in the stockroom or in the pharmacy or however they do it.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Well with the historical they use a whole different coding set and I would even say the CDX code would be difficult because you take something like the pneumococcal vaccine and there are two different types and the patient may not know which type of pneumococcal vaccine they received and so you could choose the wrong CDX code, because they're different.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Well that's what's been required for the last 5 years in the messages, so it's the current status. I think it's undersold by calling historical.

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Well and I was going to say that the...you actually might have the NDC code if you're doing like a barcode administration or something like that, so it definitely depends on kind of the setting in which you're doing it.

Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine

Right.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

I hate to cut off the discussion here; I was afraid that this was going to be a topic that people were going to want to discuss but we are at the bottom of the hour. I think we probably have to open things up for public comment at this time, at least for a few minutes to see if there are any public comments and maybe we can talk about the preparation we need to do for our next meeting while we're waiting for comments.

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Lonnie or Caitlin can you please open the lines?

Lonnie Moore – Virtual Meetings Specialist – Altarum Institute

If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

While we wait to see if anybody has called in, we received a number of comments through the public chat. Rather than take the time and share those now, we will distribute those to the workgroup via e-mail, so be on the lookout for those.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. Maybe we can talk just very briefly about our next meeting while we're waiting to see if there are any other public comments. Our next meeting isn't scheduled for two weeks, isn't that correct?

Brett Andriesen – Project Officer, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Yeah; this is Brett. Our next meeting is scheduled for July 30 and just because, in looking through what we were able to cover today and what we have left, I imagine we should probably spend a good portion of our next meeting, if not all of it, continuing to work through Section 1 topics. I think based on how we structured the agenda, we do have a little bit of time where we're going to be able to kind of group together some of the later sections as there's not as much...not as many standards or implementation specifications for those. So, let's plan to continue these great discussions for Section 1 and be on the lookout; we will get out Section 2 materials to the group to start reading through and processing those comments from the public as soon as we can.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

And if I can suggest that if people have additional comments, even on the Section 1 that they want to pass on to Brett, maybe we can collect those and make that part of the distributed materials before our next meeting and maybe accelerate the discussion a little bit. So, are there public comments?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

No public comment.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

All right, well we're a couple of minutes over; is there anything else before we adjourn for today?

Janet Campbell – Vice President of Patient Engagement – EPIC Systems

Just real quick, the question about vaccines; I double-checked. CDX does support unspecified formulations in most cases, so the pneumococcal vaccine that someone mentioned, there actually is a code for pneumococcal unspecified formulation. So I think that's kind of how they get around it, made myself an e-mail.

Robert Cothren, PhD, MS, SB – Executive Director – California Association of Health Information Exchanges

Thank you. Well thank everybo...I want to thank everybody for their attendance and their participation today; good discussion today and we'll talk to you all again in two weeks. Thank you.

Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.

Thank you, Rim.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you, everyone.

Public Comment Received During the Meeting

1. The Capture of Food Allergies and the Capture of Environmental Allergies is Critical. Physician typically ask about: Medication Allergies, Food Allergies, and Environmental Allergies. The EMR and downstream systems need to capture these three allergy types clearly and correctly, with a high level of data provenance. The Food and Nutrition EMR can get a feed from the hospital's EMR, receiving the Food Allergy information. This can be critical with meal planning. Certain foods can cause an anaphylatic reaction to certain patients. This information needs to be clearly known among the healthcare providers and professionals. T. Boyd. Hahnemann University Hospital. Philadelphia, PA
2. This overarching grouping value set is intended to support identification of drug classes, individual medication ingredients, foods, general substances and environmental entities. Value set intentionally defined as a GROUPING made up of: Value Set: Medication Drug Class (2.16.840.1.113883.3.88.12.80.18) (NDFRT drug class codes); Value Set: Clinical Drug Ingredient (2.16.840.1.113762.1.4.1010.7) (RxNORM ingredient codes); Value Set: UniqueIngredient Identifier - Complete Set (2.16.840.1.113883.3.88.12.80.20) (UNII ingredient codes); Value Set: Substance Other Than Clinical Drug (2.16.840.1.113762.1.4.1010.9) (SNOMED CT substance codes).
3. For Reactions:...code SHALL be selected from ValueSet Problem 2.16.840.1.113883.3.88.12.3221.7.4 DYNAMIC (Problem value set is a subset of SNOMED

CT codes)

4. PART 1: I disagree with the proposal to change the coding of Race from the OMB to the CDC standard. 966 CDC codes are unwieldy and impractical. If it were hierarchical, that might help, but without guidance as to the level of granularity, the results will not be statistically valid: while a few organizations may collect the most granular values such as “Ethiopian” others will use an intermediate level like “African” and most will choose from higher levels such as “Black” or “African-American.” While all these can be rolled up into the OMB standard that was required for MU2, any attempt to get useful aggregate stats at the “Ethiopian” level will be inaccurate, since there will be no way to know how many Ethiopians were subsumed in the higher reporting levels that are much more likely to be used for practicality and usability reasons.
5. PART 2: If someone ran statistics and found one Ethiopian and concluded that to be a fact, it would most likely be wrong. Wrong/misleading statistics would be worse than no statistics. Vendors could provide a drop-down list of common values (but it will vary widely among vendors), and allow for free form entry and validation of the remaining CDC codes, but very few providers and hospitals would choose to use the more granular levels, considering the burden it will place upon data collection. Thus I believe this would create burden and no benefit or even harm.
6. PART 3: The OMB standard should be retained, but there can be an allowance for EH/EPs to optionally capture more granular CDC race codes to meet particular needs in their population (e.g., those serving a high number of varied native American populations).
7. There is a national organization for LGBT health professionals who may be able to advise: <http://www.glma.org/>