



Health Information Technology Advisory Committee

Meeting Summary February 21, 2018

VIRTUAL

The February 21, 2018, Health IT Advisory Committee (HITAC) was called to order at 10:00 am EST by Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC) and Jon White, Deputy National Coordinator, ONC.

ROLL CALL

(Members in attendance, representing)

Carolyn Petersen, Mayo Clinic, HITAC Co-Chair

Robert Wah, DXC Technology, HITAC Co-Chair

Michael Adcock, University of Mississippi Medical Center

Christina Caraballo, Get Real Health

Tina Esposito, Advocate Health Care

Cynthia A. Fisher, WaterRev, LLC

Brad Gescheider, PatientsLikeMe

Anil Jain, IBM Watson Health

John Kansky, Indiana Health Information Exchange

Kensaku Kawamoto, University of Utah Health

Steven Lane, Sutter Health

Leslie Lenert, Medical University of South Carolina

Arien Malec, RelayHealth

Denni McColm, Citizens Memorial Healthcare

Clem McDonald, National Library of Medicine

Aaron Miri, Imprivata

Brett Oliver, Baptist Health

Terrence O'Malley, Massachusetts General Hospital

Raj Ratwani, MedStar Health

Steve L. Ready, Norton Healthcare

Patrick Soon-Shiong, NantHealth

Sasha TerMaat, Epic

Sheryl Turney, Anthem BCBS

Denise Webb, Marshfield Clinic Health System

Members not in attendance:

Valerie Grey, New York eHealth Collaborative

Andrew Truscott, Accenture LLP

Federal Representatives

Chesley Richards, Centers for Disease Control and Prevention



Kate Goodrich, Centers for Medicare and Medicaid Services
Lauren Thompson, Department of Defense/Department of Veterans Affairs
Ram Sriram, National Institute of Standards and Technology

ONC Staff

Lauren Richie, Designated Federal Officer
Jon White, Deputy National Coordinator

Welcome Remarks –

Jon White, Deputy National Coordinator (ONC)

Jon White, Deputy National Coordinator, ONC, voiced his support and thanks to the members of the HITAC, and the support of the ONC and the Administration for the work of the HITAC. He introduced **Dr. Robert Wah** and **Carolyn Petersen**, co-chairs for the HITAC. Co-chairs for the Trusted Exchange Framework Taskforce are **Denise Webb** and **Arien Malec** and the U.S. Core Data Interoperability Taskforce will be co-chaired by **Christina Caraballo** and **Terrence O'Malley**.

Presentation 1: National Committee on Vital Health Statistics (NCVHS) Committee and Workplan Overview –

Bill Stead, NCVHS Chair

Rashida Dorsey, NCVHS Executive Staff Director, HHS

Alix Goss, Chair, Standards Subcommittee of NCVHS

Rebecca Hines, Executive Secretary, NCVHS

Rashida Dorsey: NCVHS is the Department of Health and Human Services' (HHS) statutory public advisory body on health data statistics and national health information privacy. It works in partnership with the private sector, other advisory bodies and HHS to provide a collaborative forum for stakeholders to contribute observations and recommendations to the policymaking process.

Bill Stead: We are here today representing the NCVHS to the HITAC so your committee can consider points of intersection of the two committees and consider the NCVHS as a resource to the HITAC, and vice-versa.

Section 1104 of the Affordable Care Act stipulated that the Secretary establish a review committee to evaluate existing healthcare administrative transactions for which standards, code sets, identifiers or operating rules have already been adopted, to determine if they are meeting industry need and to ensure coordination as appropriate in developing recommendations with standards to support and certify electronic health record technology approved by ONC. This is one of the interconnection points with HITAC. The



Secretary designated NCVHS as the review committee and we issued our first report and set of recommendations in 2016.

NCVHS has three standing subcommittees: on standards, population health and privacy, and confidentiality and security.

The committee has eight active projects. Stead described five in more detail:

1. Predictability Roadmap
2. Chief Information Officer Forum
3. Health terminologies and vocabularies
4. Information, privacy and security beyond HIPAA
5. Next-generation vital statistics

Regarding the Predictability Roadmap, NCVHS has a steady drumbeat of testimony that there is not a predictable way to plan for changes in the standards and operating rules. So we are in the process of trying to figure out how we might provide more predictable planning efforts, so that the industry could plan for where resources are going to be needed and coordinate that planning across what are currently relatively independent regulatory requirements.

We need to be more predictable and we need more rapid update to meet the business needs of the industry. Those dimensions conflict a bit. So we are in the process of trying to identify actionable, short-term improvements that can be made and then longer-term opportunities.

In spring 2017 we developed a comprehensive grid of the methods by which each of the standards development organizations and operating-role authoring entities conduct their updates. We held a design workshop in August where we brought together those organizations plus industry stakeholders to discuss and identify challenges and opportunities.

We're in the process of developing recommendations and getting input from the industry on those recommendations.

The CIO forum is a one-day conference scheduled for May 17 this year. We solicit input from a diverse group of Chief Information Officers who are the end-users, if you will, of the standards and operating rules. We want to harness their vision for what predictable updates to the technology and the related standards and operating rules might look like from that implementation perspective. Also to determine the ideal schedule for updates and what improvements would they propose into the way the standards are adopted and updated to deal with the changing business climate.



Another project is around health terminologies and vocabularies. The NCVHS charter calls for the committee to study issues related to adoption of uniform data standards for patient medical record information. In addition, the committee is to advise on health data collection strategies and review and monitor the department's data and information systems to identify needs, opportunities and problems.

NCVHS last took a broad look at health terminology and vocabulary back in 2003. Now that we are through the transition to ICD-10 and iCD-10PCS, we decided it was time to step back and take a fresh look. The National Library of Medicine is staffing this work. We think this may be another point of intersection with HITAC.

Regarding health information privacy and security beyond HIPAA, we consider other potential levers that might work in conjunction with HIPAA to better preserve privacy, confidentiality and security while addressing the opportunity to use data to advance health as data moves back and forth across that regulated/unregulated boundary. We are going to work to develop use cases. One issue is our clinical data registries, where those registries receive data from covered entities and is protected in the covered entities' hands, but those registries are maintained by entities that are not covered entities

The second use case will be consumer devices. We're hoping to work our way through them and issue recommendations related to what we hear by the end of the calendar year 2018.

The final project I will mention is the next generation vital statistics/data access project. The current vital statistics system is a federated and vulnerable network of jurisdictional data capture components. The question is how we might make that much more robust while still maintaining its essential federated nature and we will get into birth, death in various population and public health data.

We would like to explore approaches to collaborating and understand how we can best support the ONC and HITAC and what role we can play that would be useful in the short term as you are moving through this aggressive schedule.

Genevieve Morris is going to brief NCVHS on HITAC at our May 15 face-to-face committee meeting. We have also initiated direct communication between the standards subcommittee in the ONC technical team. The committee plans to provide comments on the U.S. CDI and its proposed expansion process in the next few weeks.

HITAC Member Discussion – Presentation 1

Steven Lane: I was particularly struck by the work you are doing on the predictability roadmap. The USCDI Taskforce will be tackling how to create predictability for the



industry, for developers and clinicians, etc. I'm interested in learning more from your group about how you approach that and what you find working well. It would seem that if our groups could have similar methodologies that would make it even more predictable for the industry.

Alix Goss: The predictability roadmap for me is something that is long overdue. We need to enable business to innovate. To Steven's point, there is a privacy aspect related to that and to the Beyond HIPAA and ongoing work of our privacy, confidentiality and security subcommittees. I think it will be interesting as our full committee evolves, our feedback on USCDI and then how are standards subcommittee and HITAC can work at a more detailed level to address the administrative, financial and clinical data content needs as we move forward because that is the underpinning of interoperability.

The data harmonization aspect is at the crux of a lot of the issues for HITAC and NCVHS.

Leslie Lenert: I think the idea of updating HIPAA for the 21st Century and data science precision medicine is also incredibly important and an area where we should definitely overlap.

Data on the environment that patients are in, including socially, is an incredibly important area. Geo-linkages are the tool by which environmental and social determinants data are linked with the EHR data and there needs to be discussions on how to do that in better and more precise ways.

Clem McDonald: Some of the hospitals don't want more frequent intervals of dispensing code systems because they have enough trouble digesting the six-monthly one. I was wondering what you are hearing in that regard?

Stead: I think you are right. What they really want is predictability and predictability across the things that are changing for them. That needs to be faster than the changes that take decades to take place, but it's probably more in the once-or-twice-a-year range, some might even say every two years. This is one of the pieces we hope to shed light on through the CIO forum.

McDonald: Okay. One other dimension is people talk about terminology and vocabulary but looking at the coding systems I know about across the spectrum, they usually are not just simply word lists and I don't know whether that is a misconception because they often have attributes attached to them of some importance. I want to make sure people realize these are often pointing to a database with other attributes in the databases.

Stead: Very good point. And how do we coordinate the development of the individual terminology sets, and I think you are right, there are more data—there are more databases



than there are lists, and how does that integrate to dissemination approaches such as NIH's Unified Medical Language System (UMLS).

Rebecca: We might want to let them know that the National Library of Medicine (NLM) has reached out to NCVHS to help them think about how to expand it to include some of these population health domains that are not well represented in UMLS.

Goss: One of the issues that has been very clear to me is needing to find a predictable approach that enables the install base to garner the efficiencies but not preclude innovators from wanting to try new methodologies for the information exchange. We have to take into account the diversity of the businesses that actually use the standards and operating roles and find a way to get that right balance between garnering administrative simplification and cost savings but still letting the market advance.

Stead: The discussion has been along the lines of could we have a floor, which was advanced in a predictable way that in essence required everybody to come to a common point in a predictable fashion and yet use modern versioning techniques to allow willing partners to use several versions.

Terry O'Malley: There is no question that there is huge overlap between NCVHS and USCDI. My question is, are there limits on how the two committees can interact within the federal advisory committee law, the FACA, and is public comment a sufficient venue for that collaboration?

Stead and Rashida: Yes, the committee will be providing comments on the USCDI and more substantive feedback.

Webb: can you elaborate on how the Beyond HIPAA use case for consumer devices is within the jurisdiction of your committee to address, versus the FCC?

NCVHS does not regulate. It convenes and develops recommendations which are for the HHS Secretary on one hand and many of them are also applicable to other stakeholders in the industry, on the other. We are responsible for in essence recognizing trends and making recommendations related to those trends. We are aware of what FCC has done and they are one of the existing sets of levers. Our roles are very different.

Raj Ratwani: As we look at the data that we are able to glean from various EHRs, the quality of the data is often driven by how it's being input into the system and that naturally brings a lot of questions around the usability and user interface that the clinicians are interacting with. I was wondering if you could comment, whether you see that as a concern? If you have a confusing display, information that could be in structured data fields get input elsewhere and becomes more difficult to analyze and extract information from



because it goes to an unstructured place. Is that a concern? And is that an area you are currently looking at or in contact with other groups about?

Stead: It is very much a concern. It is not an area that NCVHS has delved into recently. The place that it has surfaced in our work is in the next-generation vitals project because the quality of the data there is very problematic. It is more than just a user interface issue, but that is where we have seen this.

REVIEW OF AGENDA AND APPROVAL OF MINUTES

Minutes for the January 18th HITAC meeting were approved by voice vote. None opposed.

Presentation 2: HITAC Policy Framework and Schedule Review and Committee

Vote – *Carolyn Petersen, HITAC Co-Chair*

Robert Wah, HITAC Co-Chair

Carolyn Petersen described the charges to the HITAC, the specific deliverables and the schedule for the committee's workplan. These were described in detail in the minutes for the January 18th meeting.

Steve Ready: What precisely is the deliverable of our committee on this policy framework? What exactly are we expected to provide here?

Elise Sweeney-Anthony: There's a requirement that the policy framework be developed and sent to the National Coordinator by the committee. Once the committee has reviewed it, there would be an opportunity to vote on that policy framework. It then comes to ONC as a recommendation and that is part of what ONC considers in its ongoing work. The draft that Carolyn and Robert put together very much aligns with the priority target areas identified by the 21st Century Cures Act and allows for growth in that area as we proceed throughout the year.

Sheryl Turney: There may need to be some sort of strongly worded or policy related to mandated participation for some players in the landscape. Is that within the realm of policies that we could recommend?

Sweeney-Anthony: I think that is referencing the Trusted Exchange Framework, which is under consideration by the task force. Yes, absolutely, the committee can recommend whatever they think is appropriate for ONC to consider as part of that process.

VOTE ON POLICY FRAMEWORK AND WORKPLAN

The committee, in a voice vote, approved the HITAC policy framework and workplan schedule. None were opposed.



Presentation 3: Trusted Exchange Framework Taskforce Discussion –

Denise Webb, Task Force Co-Chair

Arien Malec, Task Force Co-Chair

We are going to, as a task force, develop an advanced recommendation on Part A and Part B of the draft TEF, so that we can inform the final tasks and common agreement that ONC will be publishing. For our detailed charge, we need to make specific recommendations around the language that is included in Part B, which specifies the minimum required terms and conditions for trusted exchange. Our work is broken up into four areas. The first area is around the Recognized Coordinating Entity (RCE) and making recommendations on eligibility requirements. ONC is in the process of developing a cooperative agreement. They would like recommendations to inform that development.

ONC is seeking feedback on how it might enhance and clarify the six permitted purposes and three use cases that are identified in Part B. And finally, the task force is going to make specific recommendations around privacy and security, and any particular standards and technical requirements of ONC, that they should specify for authenticating, proofing and identification.

Arien Malec and Denise Webb: The Taskforce has a representative membership including committee members and public members. It has a very aggressive schedule, meeting twice per week for the first few weeks then drafting the proposal to the HITAC, which the committee will discuss at its March 21 meeting.

TEF Taskforce membership

Arien Malec, RelayHealth, Co-Chair

Denise Webb, Marshfield Clinic Health System, Co-Chair

Cynthia A. Fisher, WaterRev, LLC

Kate Goodrich, CMS

John Kansky, Indiana Health Information Exchange

Sasha TerMat, Epic

Sheryl Turney, Anthem Blue Cross Blue Shield

Aaron Miri, Imprivata

Carolyn Petersen, Mayo Clinic

Steve L. Ready, Norton Healthcare

Anil Jain, IBM Watson Health

TEF Task Force Workplan

Meeting Date	Discussion Items
Feb 20, 2-3 pm ET	Welcome, review of TEFCA and review of Task Force project plan



Feb 23, 1-2 pm ET	Recognized Coordinating Entity (RCE) eligibility requirements
Feb 26, 2-3 pm ET	Qualified HIN definition and eligibility requirements
March 2, 2-3 pm ET	Permitted Uses and Disclosures
March 5, 2-3 pm ET	Privacy/Security Begin drafting recommendations
March 9	NO MEETING- Continue drafting recommendations
March 12, 2-3 pm ET	Review draft recommendations
March 16, 2-3 pm ET	Finalize recommendations
March 19, 2-3 pm ET	Send final recommendation to full committee for review
March 21, 2-3 pm ET	Present recommendations to full committee

Webb: Our project plan is broken up around the four specific areas that we are charged with providing recommendations. On Friday, February 23, we will be working on the eligibility requirements for the RCE. On February 26, we will be looking at a Qualified Health Information Network (QHIN) definition and eligibility requirements, followed by a March 2 meeting on permitted uses and disclosures. On March 5, we will be covering the privacy and security area. We expect to finalize those recommendations the next week, be able to advance our final recommendations to the full committee for review on the 19th, and then deliberate during the HITAC meeting on the 21st.

Clem McDonald: Is your Taskforce’s work in response to the draft TEF?

Webb: Yes, we are taking what is spelled out in the TEF, in the draft, and we are starting from that, addressing specific questions that need further clarification. We are also asking our task force members to go back and look at the actual legislation because that can inform the discussion.



Steven Lane: I have had a chance to read a number of the public comments on the draft TEF. In more than one of those instances, there was a request for another round of public comments. Is that in the ONC plan?

Genevieve Morris: There won't be another round of comments as we are drafting the final TEF. But toward the end of the year when we work with the RCE to develop the full cooperative agreement, which would be developed with ongoing stakeholder input, we will do another round of comments later on. That is the plan as it stands right now.

Presentation 4: U.S. Core Data Interoperability (USCDI) Task Force Discussion –
Christina Caraballo, Task Force Co-Chair
Terrence O'Malley, Task Force Co-Chair

Christina Caraballo: The USCDI's overarching goal is to review and provide feedback on the USCDI structure and process. We have four specific charges that we need to provide recommendations on. The first is mechanisms to receive stakeholder feedback regarding data cross priorities. The second is the proposed categories for data characteristics. Third is how the CDI would be expanded, and by how much. And fourth, any factors associated with the frequency with which it would be published.

We thought it was important to define, first of all, who this broader ecosystem is. ONC has put in some use cases and target populations that they have identified. These include behavioral health, long-term and postacute care, individual access, public health, emergency medical services, pediatrics, social determinants of health, transitions of care, provider directory services, and clinical quality measures. Our goal is to get even more stakeholders to identify more use cases,

The draft USCDI version 1 started by reflecting the data classes referenced in the 2015 edition CCDS or Common Clinical Data Sets, adding clinical notes and provenance. We are looking to continue to lay the foundation to build on how we prioritize the next group for the next version.

Terrence O'Malley: In choosing the USCDI Task Force members, we wanted a mix of people from the HITAC membership and public members who represent either previously underrepresented sectors with interest in interoperability or groups such as nursing—as opposed to medical, because we have a lot of MDs on the HITAC—and make it as broadly inclusive as we could. That is so we could come up with a method that prioritizes data classes to represent the broadest stakeholder population.

HITAC USCDI Task Force Members:

Christina Caraballo, Get Real Health, Co-Chair

Terrence O'Malley, Massachusetts General Hospital, Co-Chair

Nancy Beavin, Humana



- Rich Elmore, Allscripts
- Valerie Grey, New York eHealth Collaborative
- Leslie Kelly Hall, Healthwise
- Rob Havasy, HIMSS
- Laura Heermann Langford, Intermountain Medical Center, Healthcare Services Platform Consortium
- Eric Heflin, Sequoia Project
- Kensaku Kawamoto, University of Utah
- Steven Lane, Sutter Health
- Clem McDonald, National Library of Medicine
- Kim Nolen, Pfizer
- Brett Oliver, Baptist Health
- Mike Perretta, Docket
- Dan Vreeman, Regenstrief Institute, Inc.

O'Malley: Regarding the Taskforce workplan, on March 21, we will present some draft recommendations to the HITAC. And then in the four weeks that follow that, we will prepare a draft set of final recommendations for consideration.

USCDI Task Force Workplan

2018 Meeting Date	Discussion Items
Feb. 21	Discuss USCDI Task Force charge, scope, and feedback
Feb. 28	Mechanisms and approaches to receive stakeholder feedback regarding data classes and elements
Mar 7	Proposed categories to which data classes would be promoted
Mar 14	Objective characteristics for data class promotion Prepare Draft Recommendations for HITAC review
Mar 21	Draft recommendations shared with HITAC committee Continued discussion on objective characteristics
Mar 28	How the USCDI would be expanded and by how much
Apr 4	Frequency of USCDI would be expanded and by how much
Apr 11	Update and refine recommendations
Apr 17	Finalize recommendations
Apr 18	Present recommendations to the full HITAC



Ken Kawamoto: Specifics within a data class can be a part of our charge, and consideration, for example medications might already be in the core data set, but, in our implementation, using our EHR systems and it might be that the route of a medication is left up to whatever the vendor decides they want to use. Could you comment on how we want to approach that, if at all?

O'Malley: On the one hand, data is going to have to be granular enough, and specified sufficiently, so it can actually be interoperable. However, we are operating initially at a much higher level. Our goal is to see if we can develop a process that is transparent, inclusive, reliable, and understandable, that allows data classes to be proposed. Then we want to have a similar reliable, clear, public, transparent process to advance them in a more detailed manner.

Carballo: We want to make sure that we are creating a framework, as Terry was saying, we will look at some of the proposed data elements more as examples, to apply them to the framework. But, not diving into the weeds of the actual data sets.

Kawamoto: I do think having a strategy, at least maybe on the ONC side, of how we are going to get operability in these items, is good. In my talks with vendors, there was general consensus that we are probably, for the things that are defined, around 85% interoperable. It would just be good to have a strategy for how we are going to get closer to 100%.

O'Malley: It also bears on how we prioritize data classes, going forward. If that 85% that have mature standards, and have granularity sufficient to operability, do we push them to the front of the queue? Because they are ready to launch? Or, do we need to make room in this process for data classes that are relatively underrepresented? Across the continuum of care? That is one of the conundrums we are facing.

Carballo: And we are trying to get to that 100%. Part of this is so that we can clearly see where the gaps are as well as to come out of this with a much clearer understanding of what is needed. So it will be easy to have kind of a next steps as well.

Kawamoto: Maybe along those lines, it would be nice if we could do something voluntary? For example, maybe Sasha TerMaat could facilitate such work with the EHR Association, if we have a standard, etc. I'm imagining like a grid that is voluntarily reported, how each vendor supports the standards.

Cynthia Fisher: If you look from a patient and physician perspective on economic impact, and time impact in care, adding films and labs and pharmacy results, which are already in storage networks, shared interstate, that would make a huge financial impact.

Stephen Lane: Cynthia, I agree that looking at these value propositions, related to each of the data types, is going to be important dimension for the work group to consider. The



other thing that I would add, and echoing what Ken said, is the idea of a grid, in looking at the various vendors, which standards they embrace. But, digging down deeper into how they are constraining the standards. How they are implementing it? And really thinking about how this is going to be tested.

The question for us is, what is the role of this work group or taskforce, compared to other groups? That is going to be one of our biggest challenges here, assuring that we are fully aware of the other work that is going on within HL-7, what is being done by The Sequoia Project, and other groups in this space, so that we can align with and support that effort, and not duplicate it.

McDonald: Providers are getting all the data. But no one else is. I don't hear it from practitioners. They don't get labs or x-rays or anything from outside. Second thing is, if we could send it anywhere, we can send it everywhere. So, we shouldn't have to worry about if we are sending it to office practice, or home healthcare, or wherever. Right now, we don't have good ways to send it. We just need ways to send it and get it out of the sources. Thirdly, I think we have got to talk about specifics. I have been in too many committees that talk about processes and stuff, and it never changes anything.

Leslie Lenert: I would just like to ask what the plan is for inclusion of the public health perspective in these data elements, and rapid exchange of data is for public health purposes is really critical for response to public health emergencies, and pandemics and such.

O'Malley: There is a wide spectrum of views and priorities on what data and data classes would significantly advance the work in each of these sectors. I think that is part of the challenge of the committee, is to, first of all, get the inputs of the stakeholders that we think are critical. And, perhaps the committee could comment on nominations of stakeholders.

Malec: These kinds of coordinating organizations that include providers, as well as HIT developers, are useful to make sure that the USCDI roadmap has a place to go. There is a gap between standards creation and rate of testing, deployment, and adoption. And finally, I would urge the committee to go back and look at a report that Stan Huff and I wrote looking at standards and interoperability to make sure that we have a thoughtful roadmap that contemplates, not just the data classes, but also standards development, testing, rollout, and adoption.

Carballo: Working in tandem with the different groups leading the charge in development of standards will be an important part of building this foundation that we are working on with the USCDI.

Sasha TerMaat: The EHR Association has been working on the first edition of our interoperability survey of our membership, where for the first time we are collecting



statistics from all of our members on actual use of standard, transaction counts, and so forth, for different standards that are available for cases.

Kawamoto: The actual mapping needs to happen at the healthcare system level. You need to actually be looking at the examples, know your ordering patterns, etc. I want to bring into this forum, the notion that we can't just put all the expectation on EHR vendors. We have to have some expectations of what healthcare organizations will be doing to make the mappings correct, for the things that we, as a community, feel should be mapped and should be interoperable

Stephen Lane: Not only is there an opportunity for us to prioritize data classes, or types, as we have called them, but also, within those classes, prioritizing the data elements.

McDonald: There is an infinite desire for more data. We have to realize that providers, nurses, and physicians don't have an infinite amount of time anymore. Another thing about the lab data, there is an evolution coming, that the instrument vendors are providing mapping of their internal test codes, to blank codes.

Tina Esposito: These comments are all good. It is very easy to get into the weeds in terms of data elements. I appreciate the comments to ensure the framework and the process is correct. The one comment I would have is that we think about the use cases that would be defined. It is important to ensure that it is a broad spectrum. I know we said two or three. Within those handful, ensuring that we are considering all stakeholders. I was happy to hear providers beyond physicians.

Doctors are obviously key, but other clinicians are incredibly important. Patients, healthcare systems, vendors, and also, just think about use cases, another element is certainly point-to-point care. The physician's office. Echoing, or following up on the comments earlier around uses like the CDC, analytics. the details will come, and it will be the right detail if we identify the right use cases.

O'Malley: I have a question for the committee as a whole. And, that is, could we give some thought to either use cases, or stakeholders, or broad domains of data, that appear to fall outside of the current domains and stakeholders listed in the draft USCDI? I am asking if we could get an explicit response to places where this process should go, or conversely, where this process should not go.

Clem McDonald: We can sense that the committee is pulling at their harnesses trying to talk about specifics, but it is maybe forbidden by some higher authority?

Lauren Richie: I can speak to the 21st Century Cures Act lays out what the HITAC absolutely must do.



Genevieve: I will just jump in there. I think the goal, Clem, is that the process comes first, and once that is in place, then the process itself can be used for the committee to discuss the actual data classes themselves. I think the concern that we have at ONC is that the USCDI is our best guess, based on what we have heard from stakeholders in the last two to three years.

Kawamoto: As much as I like structured data, the first part is just making sure that anything can be readable, that folks want, is there. Limited to things like notes is amazing and great. Once we do that, and we start focusing on the structured data, my recommendation would be to focus on the core, and avoid getting too much into scope creep. It is better to harden up what we already have, and make sure that is truly interoperable, before we say let's look for additional things to add into the structured data we want to share.

McDonald: I agree. As part of nonstructured narrative text, I hope these include radiology reports.

Terry O'Malley: Thanks for the last two comments, Ken and Clem. It is a reminder that machine readable data is only readable by people with machines. And, meaningful use and HITAC only go so far across the healthcare spectrum. The emphasis on text is probably a really good one, if we are trying to engage a much broader group of clinical actors. So, thank you for those two comments.

Public Comments:

There were no members of the public wishing to comment at this time.

NEXT STEPS

The next meeting of the HITAC is scheduled for March 21, 2018.

Lauren Richie adjourned the meeting at 1:00 pm