



U.S. Core Data for Interoperability Task Force

Transcript
February 21, 2018
Virtual Meeting

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

Hello, and good afternoon. Welcome to the virtual meeting of the U.S. Core Data for Interoperability Task Force. This is the first of many meetings. I am Lauren Richie, the Designated Federal Officer. I will call the meeting to order and start with the official roll call. Christina Caraballo?

Christina Caraballo – Get Real Health – Co-Chair

Present.

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

Terry O'Malley?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Here.

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

Brett Oliver?

Brett Oliver – Baptist Health – HITAC Committee Member

Here.

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

Clem McDonald?

Clem McDonald – National Library of Medicine – HITAC Committee Member

Here.

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

Ken Kawamoto?

Ken Kawamoto – University of Utah Health – HITAC Committee Member

Here.

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

Steven Lane?

Steven Lane – Sutter Health – HITAC Committee Member

Good afternoon.

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

Hello. Valerie Grey? I believe she's absent. Dan Vreeman? Do we have Dan on the line? Eric Heflin?

Eric Heflin – Sequoia Project – Public Member

Present.

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

Kim Nolen? Do we have Kim on the line? Laura Heermann Langford?

Laura Heermann Langford – Intermountain Healthcare – Public Member

Here.

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

Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Public Member

Good afternoon.

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

Hello. Mike Perretta?

Mike Perretta – Docket – Public Member

Good afternoon.

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

Nancy Beavin?

Nancy Beavin – Humana – Public Member

Present.

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

Rich Elmore?

Rich Elmore – Allscripts – Public Member

Here.

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

Rob Havasy?

Rob Havasy – HIMSS – Public Member

Here.

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

Okay. Thank you all. With that, I will introduce and turn it over to the task force co-chairs, Christina Caraballo and Terry O'Malley.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great. Thanks, Lauren. Welcome, everyone. Thank you all so much for agreeing to be part of this endeavor. We are going to have a quick sprint over the next couple of months, but it

should be engaging and fun. At least, we hope it will be. Next, I would like to go through the list of who we are. This is the list of who we are. I thought we could spend a few minutes just running down the list, so that each of us can take 30-45 seconds to give a blurb of where you are from, what you do, and why you're on this committee. Christina, perhaps we will start with you, and then I will follow.

Christina Caraballo – Get Real Health – Co-Chair

Sounds great. Welcome, everyone, and I echo Terry's excitement to have everybody here today. I am Christina Caraballo. I'm from a company called Get Real Health. We specialize in consumer engagement. I am located in Washington, D.C., and I consider myself an advocate for everything we're working on to increase the adoption of Health IT interoperability and access to health information. Terry, I will pass it back to you.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Okay. I am an internist and geriatrician. I take care of a bunch of very complex, frail, elderly people. My interest in this is in transitions of care and longitudinal coordination of care, and interoperability just becomes the key pillar to that. I'm going to pass it on to Brett.

Brett Oliver – Baptist Health – HITAC Committee Member

Good afternoon. Brett Oliver. I am a family physician by trade. I still practice one day week, but I am also the Chief Medical Information Officer for Baptist Health in Kentucky and Southern Indiana. We're an Epic shop. My interest is with the provider end of things, making sure with all this interoperability, which is wonderful, that we present data in workflows that are important to the clinician and not just more stuff to wade through.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Are we going in the order of the list?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yes, we are, Clem. You're up.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Okay. I am Clem McDonald. I am from the National Library of Medicine, NIH, but spent decades working with medical record systems and physicians, and they ended up being happy in that environment. I go along with Brett, in that we want to make it work for at least for physicians; it should work for everybody. I'd like to see the facts get across the different systems successfully. I don't think that we are there yet.

Ken Kawamoto – University of Utah Health – HITAC Committee Member

This is Ken Kawamoto. I am an associate CMIO at University of Utah Health. I've been asked to engage in standards, and we are implementing a variety of things like SMART on FHIR apps

to get the services for production purposes. I would like to provide some pragmatic boots-on-the-ground perspectives, along with my colleagues here, to help make these standards better and more usable.

Steven Lane – Sutter Health – HITAC Committee Member

I am Steven Lane. Continuing with the pragmatic approach, I am a practicing primary care family physician. I am a clinical informaticist at Sutter Health out on the West Coast. We at Sutter have been early adopters of a number of interoperability solutions, including the Epic supported Care Everywhere network, eHealth Exchange, Care Equality, Direct Secure Messaging, and now FHIR based apps. So, we bring a lot of practical experiences to your discussion. I also help to lead a regional collaborative in California of organizations on multiple vendor systems. We're trying to not only share this data, but make full use of it, both at the point of care and for analytics.

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

Is Valerie on the line yet? I didn't hear her earlier. Dan? I don't believe Dan has joined us, either. Eric?

Eric Heflin – Sequoia Project – Public Member

Good afternoon, everybody. Thank you for the honor of being involved with this task force. I am Eric Heflin. I am the CTO and CIO of the Sequoia Project. I also have the second role of being the Chief Technology Officer and CISO of the statewide Health Information Exchange for the Texas Health Services Authority. Both organizations are nonprofits organized for the public good, to lessen the burden of health information exchange and facilitate that. I am a software engineer and computer scientist architect.

I have been involved with the Nationwide Interoperability Health scope projects since the inception of the Nationwide Health Information Network – about 10-12 years ago. I've been involved from that point forward, as my real career focus, is broad scale interoperability, security, privacy and supporting patient access to expressions of patient privacy preferences. I am very much looking for to our task force.

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

Has Kim Nolan joined us? Okay, we will move on to Laura.

Laura Heermann Langford – Intermountain Healthcare – Public Member

Hi. Thank you. I'm Laura Heermann Langford and I am from Intermountain Healthcare, not Indiana University. I work for Intermountain Healthcare as a nurse informaticist. I also am the Chief Operating Officer for HSPC, the Healthcare Services Platform Consortium. I have a lot of history looking at nursing data, nursing standardization of the data and information exchange, and also interoperability through IEG and HL7, etc.

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

Leslie?

Leslie Kelly Hall – Healthwise – Public Member

Hi, I am Leslie Kelly Hall. I am the Consulting Executive for Policy for Healthwise, a nonprofit committed to helping people make better health decisions. I am a former Chief Information Officer and Chief Marketing Officer at the Health System of Idaho. I'm a former member of the Health Information Technology Standards Committee. I've worked on patient generated health data and I am a member of the Direct Trust Board of Directors and the Care Equality Steering Committee. I advocate for patients' rights in health information technology. I am thrilled to be part of this. Thank you.

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

Thanks. Mike?

Mike Perretta – Docket – Public Member

Hey, everybody. This is Michael Perretta. I am the founder of Docket.care. It is a patient engagement and appointment onboarding application that leverages newer technology, such as HL7 FHIR. I've been involved with ONC over the past two years or so, as part of their Move Health Data Forward Challenge, and have been involved heavily in implementing their Health Relationship Trust, or HRT, specifications. I am based in New York City and I am very excited to be part of this task force. Thank you.

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

Thank you. Nancy?

Nancy Beavin – Humana – Public Member

Hi. I am Nancy Beavin. I work in Louisville, Kentucky for Humana. I am the Strategic Interoperability Leader for Humana. I help direct Humana's strategy for interoperability for medical records and clinical bidirectional data between payer, provider, and patient. I am very passionate about interoperability on the national **[inaudible – recording cuts out]** **[00:10:28]** and nation scale. I am on the Steering Committee for Care Equality and on the Board of Directors for the Sequoia Project. I have about 20 years' experience with EMRs and sharing information at the patient and provider level. I am very excited about bringing the payer perspective to our task force.

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

Thank you. Rich?

Rich Elmore – Allscripts – Public Member

Hi, Rich Elmore. I'm Senior Vice President for Corporate Development Strategy at Allscripts. A lot of my focus is on what we can do better for patients and clinicians. I am a former member of the Health IT Standards Committee and I'm looking forward to working with all of you. It's a great group. Thank you.

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

Thank you. And, Rob?

Rob Havasy – HIMSS – Public Member

Good afternoon, everyone. I am Rob Havasy. I am the Senior Director at HINS, in our Health Information Systems Group, focusing on connected health, long-term post-acute care, and care coordination issues. I was, until very recently, the Executive Director of Continua, and spent many years on the Board of Directors of Continua, working on interoperability for patient generated health data. Prior to that, I spent almost ten years at Partners Healthcare on various IT roles and integrating various data streams. It is an honor to be with you all. Thank you.

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

Thank you. I will turn it back over to the task force co-chairs.

Christina Caraballo – Get Real Health – Co-Chair

I think that we can go ahead and move on to next slide. So, it sounds like we have a lively group here. I am excited to work with all of you. I am hearing this echo of how we make standards better and more usable, and make interoperability work.

That brings us to our charge on this task force. Overarching, we are trying to look at laying more of a foundation and framework to better promote how we prioritize datasets, and how we get and generate more stakeholder involvement and use of data. So, with that, I will go into our specific recommendations.

Our overarching charge is to review and provide feedback on the USCDI structure and process. We have four specific things for which we will be providing recommendations to the Health IT Advisory Committee at the end of our eight-week sprint. The first is mechanisms and approaches to receive stakeholder feedback regarding data class priorities. Second, the proposed categories to which data classes would be promoted and objective characteristics for promotion. The third is how the USCDI would be expanded and by how much. Fourth, any factors associated with the frequency with which it would be published.

Another thing that I wanted to stay right off is that in this work we're going to try to stay very focused on creating this template, this structure and framework, as we continue to move

forward. And, our goal is not to get into the weeds at this stage of what is in the data classes specifically. That said, it is important. And, if we have time at the end of this, we can start diving into that. But, I want us to stay focused.

First of all, we think it's important to define what industry means. Who are these stakeholders were talking about? Traditionally, when we've looked at technology and interoperability, we've thought of the use cases surrounding hospitals, providers, and EHRs. We have grown as an industry to recognize that there is a whole ecosystem out there that could benefit from interoperability working. So, in the draft USCDI published by ONC on January 5th, which was in your reading materials. We are going to assume that everybody has read that document. In that document, there were a variety of use cases and target populations that ONC did identify. That does not mean that this is all of them, but it is a first step. These included behavioral health, long-term and post-acute care, individual access, public health, emergency medical services, pediatrics, social determinants of health, transitions of care, provider directory services, and clinical quality measures.

With that, I am going to pause for a moment and see if Terry would like to add anything at the stage.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Sure. Thanks, Christina. I think the two immediate jobs the for the task force are too figure out what the boundaries of the universe of engaged stakeholders should be and how far out are we going to get. How inclusive should our process be for finding nominees for data classes? That is our first job. Who should we be asking? Our second task, then, is developing a set of prioritization criteria that we can apply to any proposed data class from any proposed stakeholder in a process that would be transparent, reliable, clear to everyone, reproducible. I think that those are going to consume our early efforts. Our first job is to figure out which stakeholders that we want to include at the table for nominating data classes. And secondly, once we have a data class, how do we rank it against the other data classes that are seeking to be advanced through this process. Go ahead, Christina.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

I think we are ready to move onto the next slide, right?

Clem McDonald – National Library of Medicine – HITAC Committee Member

Is there a chance for questions?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Of course. Do you want to just go through one last slide?

Christina Caraballo – Get Real Health – Co-Chair

Yeah, and we're definitely going to open this up. If we could just get through our general overview of what we are doing, and then open it up for discussion. So, we have here our work plan. If you map it to our original four charges, we are looking at the first two items

over the course of the next 4-6 weeks, and then moving into the second. Two dates I want to point out are March 21st, where we'll provide our draft recommendations to the High Tech Committee. And then, April 18th is when we should have all of our final recommendations ready to present to the High Tech Committee.

So, with that, I guess we can go ahead and open it up to questions. I do not think that we have any more slides to go over.

Clem McDonald – National Library of Medicine – HITAC Committee Member

I don't know if I'm the first up on the list are not.

Christina Caraballo – Get Real Health – Co-Chair

Go for it, Clem.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Okay. I think that there is some blending of houses and airplanes. You talk about first how you want to decide who the stakeholders are, and you list as a stakeholder social determinants of health. That is not a stakeholder. That is a class. I think that we have to clean it up a little bit. The other part is, I can see that different stakeholders wanting to put up different things. It just seems like you've mixed a couple of different kinds of entities. If we're talking about stakeholders, it shouldn't be classes of data.

Christina Caraballo – Get Real Health – Co-Chair

Yeah. And, to clarify, it was broad things that we are thinking about. So, the bundle I gave were the classes that span a wide variety of use cases and target populations. It was kind of a blend. Good clarity on that.

Clem McDonald – National Library of Medicine – HITAC Committee Member

You defined it as stakeholders. I'm still confused. When you initiated the discussion --

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Right. There is a blending there, Clem. One of the ways to think about this is, what sorts of domains or identifiable stakeholders should we be looking at to find candidate data classes? So, one of the ways to categorize those domains might be the types of care. Is it medical or surgical or nursing or behavioral or therapies or dental?

Clem McDonald – National Library of Medicine – HITAC Committee Member

I get that. But, if you put in social determinants, those are variables and I would --

Terry O'Malley – Massachusetts General Hospital – Co-Chair

No, no. I understand. But they --

Clem McDonald – National Library of Medicine – HITAC Committee Member

Radiology reports would be a competitor with that.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Fine. Understood. You might also look at some foundational care processes – transitions of care, longitudinal care planning, and patient and individual identification. And, it may be big processes like public health, regulation, payment, and quality. And then, there are a bunch of nontraditional healthcare providers that are way out on the edges, like schools and the criminal justice system. So, if we think broadly about who might be interested in proposing data classes for considerations under this project, our first job is to figure out what that universe looks like. The second job, which I agree, Clem, is to clean up what we mean by data classes and develop the prioritization process.

Eric Heflin – Sequoia Project – Public Member

This is Eric Heflin. I have a comment, if now is a good time?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Sure. Please.

Eric Heflin – Sequoia Project – Public Member

I do agree with the intent of the prior discussion. I would reword it, though. Again, not disagreeing, but just trying to clarify further. As a software engineer, I never know if something I create is adequate or not unless judged by the expected outcome. And, how I typically think that it should be judged is in terms of use cases. So, I respectfully suggest we consider, as part of the process portion of our charge, injecting use cases as part of the discussion. Because that will give us a way to ascertain whether a given data class can, in fact, meet the needs of a specified use case. The reason is otherwise, in the absence of some type of a use case driving the data classes, it is going to be very hard, if not impossible, to judge whether or not we're done, we have it right, we have gaps, or we have missed the mark entirely.

Leslie Kelly Hall – Healthwise – Public Member

Hi, this is Leslie. I have another question, or perhaps a suggestion. Looking for what are the real principles, of not just the use cases, but the guiding principles of the process. Are we looking at things that are easily adoptable? I heard earlier in the workflow, use case specific with outcomes generated? Are we looking for a process that addresses a certain percentage of stakeholders versus two or three? Are all of those things up for grabs as we define the process for expanding these candidates of data?

Christina Caraballo – Get Real Health – Co-Chair

Yep. Starting with Eric, I think it is a very good point to have the use cases defined. As we look at building out our recommendations and this framework, it probably would be extremely instrumental to add an area where we clearly map the use cases to the different data classes and incorporate that in even maybe a chart that is in the USCDI, so it is clearer. I would say that is an excellent point. And then --

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Thank you for that feedback. I appreciate it.

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

Just a quick point of process. This is Lauren again. Just a reminder for the task force members to please use the hand raise option if you have a comment or question. I see a hand's been raised. I just wanted to acknowledge that.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Good reminder. Thank you, Lauren. So, everyone, use the icon at the top with the hand up if you want to get in the queue to make a comment.

Christina Caraballo – Get Real Health – Co-Chair

I think I see Steven Lane with a hand up.

Steven Lane – Sutter Health – HITAC Committee Member

I was trying to be good since I got my hand slapped for not raising my hand in the last meeting. I have to figure out how we play by these rules. So, I'm very excited with the idea of starting with the stakeholders. I guess I am curious, what is our plan? Are we going to use the next 29 minutes to start to do some of this work? I have been jotting down stakeholders. And, Terry, you mentioned types of care. There is a lot here. Are we going to roll up our sleeves and do the work here or are we going to go home and work on some documents and send them around in between meetings? I'm just curious about how we are going to start moving.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

The answer is yes. We are going to do both. We can have some more general discussion for a few more minutes, just to make sure that we get some of the big issues out. After that, we can dive into thinking about what the universe is. And then, between meetings, Adam and Stacy, the support team for this endeavor, will put together homework and we will hope to get more feedback from you in time to present it at the next meeting. We will get it out to people before the meeting, so it can be reviewed and we can go from there.

Steven Lane – Sutter Health – HITAC Committee Member

If I could just continue my comment a little bit. I know that we have received some specific public comments on the USCDI portion of the draft documents that were released. I trust that the committee as a whole will have a chance to review those. I submitted some USCDI comments. I've sent the task force chairs some emails with other thoughts coming out of groups I've been working on, and people have been sending me emails. So, I want to make sure that we also know how to best channel input that we either have as individuals or we have received as members of the task force into the process for everyone's consideration.

Christina Caraballo – Get Real Health – Co-Chair

This is Christina. A friendly reminder to everyone to state your name as well. We have asked ONC leads to get us those comments, if possible. We are not sure if we are going to be able to get them or not. And, we are also trying to get a list of different stakeholders who have submitted comments in the hope that we can identify the types of groups that are commenting, as well as those who we have identified as potentially benefiting from the USCDI but are not commenting, so we can better understand the group that we are looking at.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Steve, that is a great point. Go ahead, Christina. Sorry.

Christina Caraballo – Get Real Health – Co-Chair

No, I'm good. I think we have Rich next on comments.

Rich Elmore – Allscripts – Public Member

Hi, Rich Elmore. So, I have read the USCDI document. It was not clear to me what the levers are that make it possible for this to achieve nationwide scale and adoption. So, I didn't know if you have any insight into that. I think it is important for us to understand because I think this group should be thinking, in part, about feasibility and about deployment implications of whatever process recommendations are being made. So, for example, depending on who you talk to – let's say that it is five to eight years to get from initial discussions about a standard to the time that it's deployed in clinical sites and available for real interoperability. The idea of doing annual updates needs some consideration, that part of the process, given that kind of cycle time. Secondly, I want to make sure that we understand what are the levers that are going to be used to make this real?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Hi, this is Terry. Another great question and a great point. The implication in the USCDI draft document is that recommendations that come forth out of this process regarding data classes be looked upon as ONC's policy statement, that these are going to be important and promoted. I'm not quite sure that gets exactly to your levers. I do not know what the real levers are behind that.

Rich Elmore – Allscripts – Public Member

No, it doesn't. I am looking at that segment right now, and that is part of what is raising the question. With other rounds of standards, there was regulatory foundation for ensuring that EHRs were certified and could support a common clinical dataset. I am looking for what are the mechanisms that are going to be used to ensure that this gets broadly deployed and probably adopted, so that it can be used on a nationwide scale for exchange. What is the intention?

Christina Caraballo – Get Real Health – Co-Chair

This is Christina. I think that you have hit a key problem that we are trying to solve. I think that it is up to this task force to provide recommendations on how we do that. Even with our first bullet, which is mechanisms and a purchase to receive stakeholder feedback regarding the data classes and elements. How do we generate people, and different stakeholders, to actually be interested in the USCDI and start commenting and become more involved? I think that definitely plays into an area that we need to start looking at.

Rich Elmore – Allscripts – Public Member

It may be that Steve Posnack or someone at ONC can give us more specific guidance on this, but I would think that we want to understand the answers to those questions before we get into specific areas of what data we are going to make recommendations on. Or, should it be part of the charge of this group to come back with recommendations on those broader process and regulatory questions? I would be surprised if it were.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

This is Terry. I would be surprised, too. I do not think that is quite within the scope of our committee, but it is a critical issue. I think that Steve is a very good person to give us the first draft of the answer. We will chase that down. Thank you for that point.

Christina Caraballo – Get Real Health – Co-Chair

I think we have Michael up next.

Mike Perretta – Docket – Public Member

Hi, everybody. Mike Perretta here. This is a quick practical question. Is the plan here to set up some sort of shared or living document, such as -- not like a Google Doc, but maybe using ONC's [Giraboard \[00:34:42\]](#) or something, so that when we are all going off in our own directions and collaborating on this, we are not duplicating each other's efforts and we can all stay in sync in a way?

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

This is Lauren from ONC. We actually had a similar question with the Trusted Exchange Framework Task Force yesterday. We're looking into potential online collaborative tools we

can use for the task force. It needs to be something that we can both use on the ONC side and the member side.

Mike Perretta – Docket – Public Member

Oh, thanks. Okay. If I may recommend any, Trello has worked very well for me in the past. But, any sort of shared document would be tremendously helpful.

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

Okay. Thanks for the recommendation.

Christina Caraballo – Get Real Health – Co-Chair

Clem, I see you next with the hand up.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Yeah. Back to the stakeholders. I can see that stakeholders are good people to list so you can make sure these are the people that should be suggesting things. But, in some sense, I do not understand what difference it makes. If we can get the data to go to anybody, we can get it to go to everybody almost. Unless we're talking about new data that does not exist anywhere, like requiring more additional data. I would like to at least have that distinction. Are we really going to encourage people to say the hospital assistants, physicians, nurses have to enter more data so that these additional requirements can be met? Or, are we saying that we want to facilitate the data that exists and make sure it's standardized enough to send?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Clem, this is Terry. Again, a good point. But, I think that will be a process that we work through when we figure out the prioritization schema. You can think of many different ways to prioritize data, and one may be that it is available, has mature standards, and is ready to go. So, the issue is how do we get it to everyone who needs it, versus your other mention of data that is not routinely collected and is not based on standards yet. Then, you have an eight-year cycle of getting a standard in place.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Leaving out the standards, then we're opening up to say we're going to give everybody – somehow the system is going to write down or record in any form **[inaudible – cell phone ringing] [00:37:31]** recorded. It's a different set of problems and a different set of barriers. If that is on the table, I would just like to know.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

I'm sorry, Clem. This is Terry again. Can you repeat that? I had an interruption.

Clem McDonald – National Library of Medicine – HITAC Committee Member

The question really is, are we asking the world to say what would you wish that every clinical system actually currently recorded somewhere. Leave out the machine readable. Leave out the communication. Is it a new kind of requirement on the care system, which makes it tougher to implement? Or, is it just that data which is around, and we just aren't sending it well? I think that you're saying that it can be both. But, I think we should get that clear, that we're going to be asking additional work of the labor force in healthcare if the latter is what's on the table.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

I think that we probably will come up with data classes that are currently not on the draft list. So, to the extent that they --

Clem McDonald – National Library of Medicine – HITAC Committee Member

I'm not talking about the draft list. I'm talking about currently not in anybody's system.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

And it may be. I'd say yes, there may be.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Alright. We'll just have to keep the distinction really clear because it's a different burden and effort to get that kind of stuff done.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yeah, I understand. But, I put that in the prioritization category, I think.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Okay.

Christina Caraballo – Get Real Health – Co-Chair

I will just add that part of the goal is not to add more requirements, but to create a place where we can better understand what we have and what we do not have to help drive the industry to fill some of the gaps that we have in the available datasets that could make a significant impact. So, I think, next, we have Steven.

Steven Lane – Sutter Health – HITAC Committee Member

Thanks. To Clem's point, I think it's wonderful that we are thinking about not adding additional burden on providers or other clinicians to collect data. But, I think that we need to

keep a very broad view of this. There are going to be other sources of data, beyond clinical systems. And, we talked earlier today about some new OMEKs [00:40:13] that some of us had never heard about. There are all of the OMEKs, all of the social determinants, and so much of the patient generated health data, which is nowhere near our clinical systems today. But, that will certainly become important as we try to tackle the core data for interoperability more generally.

So, while I think we have great physician representation, we have nursing representation, and some patient advocacy here on our group, we do not, as far as I can tell, have some of the new generation of technology vendors represented. We have some public health representation, but we do not have anybody thinking about things like disaster relief. I think we have people here who work with standards development organizations, which is great. But, I think, starting as you said with who might we need to reach out to, to make sure that we're collecting all of the right opinions, is a good way to start. We can make that list of stakeholders – patients, caregivers, providers, etc. – but there may yet be some that we are not even considering, given the scope of our own thought.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Thank you. That is a great comment.

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

So, Christina and Terry, we have just about five minutes left of discussion before we have to open it up for public comment.

Christina Caraballo – Get Real Health – Co-Chair

Okay, I guess we'll move down. Leslie, do you want to go ahead?

Leslie Kelly Hall – Healthwise – Public Member

So, thank you. With the end in mind, when we have these recommendations completed, for the nation, we will know how new datasets will be considered, what the datasets are – or perhaps the stakeholder benefits and the breadth of use. We may know the availability of data and the emerging technologies that impact this dataset. These could be all considerations that we have. I'm trying to get to the end in mind, as people would know how the process works, how things would be considered, and who would be involved. Is that correct?

Christina Caraballo – Get Real Health – Co-Chair

Leslie, I would say that is spot-on.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Absolutely. We're going to write it down. [Inaudible – crosstalk] [00:42:50] the week.

Christina Caraballo – Get Real Health – Co-Chair

I do see that Adam has his hand up. I want to go ahead and pass it over to Adam.

Adam Wong – ONC – Management and Program Analyst

Sure. Thanks. Hi, this is Adam Wong. I am one of the ONC staffers. I want to add a couple of things with regard to some points that were presented before. One of them is the availability of public comments that have come in so far. Those will be released publicly on HealthIT.gov in about a week or so. And then, there was a question about the process of enabling and enacting the USCDI. It's the Trusted Exchange Framework that is going to be the lever for doing that. Thank you.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Thanks, Adam.

Christina Caraballo – Get Real Health – Co-Chair

I think that we have time for one more. Ken, do you want to go ahead?

Ken Kawamoto – University of Utah Health – HITAC Committee Member

Sure. Thanks. Ken Kawamoto. In terms of stakeholder groups, a suggestion for at least three stakeholder groups to reach out to, where I think their opinions would be valuable. One would be CMIOs, and maybe a group like Andis. One would be CIOs, and that would be a group like Chimes. And one would be HR vendors for getting an idea of what their customers are asking for. That would be like EHRA, and Sasha's on the committee. So, hopefully she can facilitate that.

In terms of what Clem was saying, I do agree quite a bit with what he was saying about focusing on what's already captured. I do think that there are places where it probably makes sense defining, if you're capturing it, how it should be shared -- things like social determinants of health, occupational history, etc. But, I think we still need to be very clear that defining how you should share something, if you collect it, isn't interpreted as you need to start collecting this. I think a lot of us on the front lines know that having providers have to do more things now for data collection because of IT standards is one way to get folks really, really upset.

Clem McDonald – National Library of Medicine – HITAC Committee Member

And they'll fight the whole thing.

Ken Kawamoto – University of Utah Health – HITAC Committee Member

Yeah.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

This is Terry. I'm in. Did that bring us to our public comment section? And, thank you all.

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

Terry or Christina, any final comments?

Christina Caraballo – Get Real Health – Co-Chair

No. Thank you all for joining. I am excited to work with everybody this coming eight weeks.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

If there are not a lot of public comments, maybe we can circle back and take the last five minutes for more work.

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

Operator, can we please open the public line for comments?

Operator

Absolutely. At this time, we will be conducting the question and answer session. If you would like to ask a question, please press star-one on your telephone keypad. A confirmation tone will indicate your line is in the question queue. You may press star-two if you would like to remove your question from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star key. One moment, please, while we poll for questions. Our first question comes from the line of Julie Skapik of Cognitive Medical Systems. Please proceed with your question.

Julie Skapik – Cognitive Medical Systems – Chief Health Information Officer

Hello. It's Julie Skapik from Cognitive Medical Systems. There a couple of points or clarifications that I would like to make. One, to Clem's comments - it sounded to me, from reading the USCDI, that the goal of USCDI is to specify exchange data elements, not necessarily those which would be used at the point of care. I think that would be something that would be useful to clarify.

Two, there are multiple levels of specificity of data elements that can be entered into USCDI. We talk about data classes, that makes me think that the level of specificity is not granular enough. In my mind, it would be more useful to have 20 highly specified diabetes data elements then say five classes that have loose terminology findings and not enough specificity to truly be interoperable.

In that regard, it sounds like there are two different kinds of data elements that you would potentially have added to your list. One would be highly specified data elements that people

want to enter for specific use cases. And two would be a wish list of things that are broader and maybe not yet well specified.

I would encourage you to have a process that allows people to bring both to the table. In regard to the stakeholder representation, while this group has excellent stakeholder representation in some areas, I would encourage the group to develop a process that allows any come to come with data elements specified at varying levels of specificity, and to allow the group to have an evaluation process that says which of these are truly ready for prime time? Which should we encourage the further development of? Which should we say are wish list things that need significant investment, but are high priority and should be considered something that the federal government might put additional resource into getting to the point that they're ready for actual use. Thank you.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Hear, hear.

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

Thank you. Just as a reminder, this is a public comments period and not a question and answer period. Just to clarify the earlier point. Operator, do we have any other public comments?

Operator

Yes. Our next comment is from the line of [Maury Savagis \[00:49:00\]](#) of Chime. Please proceed with your comment.

Maury Savagis – Chime

Hi, this is Maury. Chime would be more than happy to assist with shaping the feedback. Also, I'd like to echo the sentiments concerning use cases. We think that there is a lot of utility in looking at use cases through the lens of USCDI. Thank you.

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

Thank you. Operator, do we have another comment?

Operator

Yes. Our next comment comes from the line of Steve Hufnagel of Federal Health. Please proceed with your comment.

Steve Hufnagel – Federal Health – Director of Interactive Application Development

In response to the discussion on stakeholders, I believe that you can change the semantics and call it stakeholder domains. As an example, dental might be a stakeholder domain – or

financial or logistic. Although what I am saying is counter to what Ken suggested about CMIOs, CIOs, and vendors, I think an efficient way that you might be able to triage is to use the Federal Health Information models, which have been developed by the Federal Health architecture for over ten years, as a way to go through and look at the stakeholder domains and their maturity very quickly. I think you could waste a lot of time by not building upon work that's already available. That model is publicly available at www.fhims.org, and it is a government sponsored model. Thank you.

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

Thank you. Operator, do we have another comment?

Operator

Yes. Our next comment is from the line of Jill DeGraff, a private investor. Please proceed with your comment.

Jill DeGraff – Private Investor

Hello. Thank you very much for this opportunity to comment. I wanted to provide an echo to a comment earlier about the value of use cases, and to also provide some perspective from research that I did for the Commonwealth Fund over the summer. They were looking at what are the business model challenges for why consumer enabled IT is not being adopted more readily. Some of the thoughts that were coming up were about the need for a pull in the marketplace that is demanding the data. When people are pulling for it, that will be the impetus and that might drive the use cases that you're looking for to promote trusted exchange over at the HINS.

A reoccurring theme that came up as payers, providers, and drug manufacturers were interviewed was the need to consider the consumer's journey. It's a concept that comes up a lot in consumer digital data and marketing. It is a mindset that is very foreign to the mindset that we often adopt when we're looking at electronic health information because we are presuming that it is only data that resides inside health information records and is being used by providers. Not to discount that at all, but if you are looking at trying to unlock longitudinal data and you want to engage a consumer who may be a woman who's in the sandwich generation, managing their aging parents, their children, and their own health, then a lot of your use cases have to be thought through strategically through the lens of, what data is accessible? What data is desirable? And how can you activate that individual?

So, I do not have an answer so much as a request to maybe think about these other ways of approaching the problem, by thinking about a journey that a person is undertaking involving their health, where these various data elements can be useful to support that journey. Thank you.

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

Thank you for your comment. Operator, I believe we have time for one more.

Operator

At this time, we have no further questions over the audio portion of the conference.

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

Okay. Terry or Christina, any other final comments?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Homework is in the mail. We will send out something to you guys and ask you to have it back in by – when did we decide? Sunday night?

Christina Caraballo – Get Real Health – Co-Chair

Close of business Monday.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Could we bring up what is coming up next on the call? We could use some time to hear that.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Sure. What is coming up next call is to take the feedback that you are going to provide, and stakeholder lists, and we'll do our homework. We will pound out a list to makes sense to us. Also, in the homework, think about criteria to use for prioritizing data classes.

Clem McDonald – National Library of Medicine – HITAC Committee Member

That's what you want early next week?

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Yes.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Okay. Thank you.

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

Okay. Just a reminder to everyone, the next USCDI Task Force meeting is next week, on the 28th, at 3:30 Eastern time. If there are no other last-minute questions or comments?

Steven Lane – Sutter Health – HITAC Committee Member

Just a final comment from Steven Lane. As we mentioned earlier today, we should probably look at whether there are any opportunities to collaborate with the NCDHS work that they are doing on their predictability roadmap. I think that's going to be an important thing for us to consider, how to make the output of our committee predictable for the industry.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Great.

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

Thank you, Steven, for that reminder. Okay, with that, I think we can adjourn for today. We hope to hear from you all next week.

Terry O'Malley – Massachusetts General Hospital – Co-Chair

Have a great day.

Christina Caraballo – Get Real Health – Co-Chair

Bye, everyone.