Interoperability Standards Priorities (ISP) Task Force

Transcript
July 31, 2018
Virtual Meeting

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Thank you. Good morning, everyone, and welcome to what is now our second meeting of the Interoperability Standards Priorities Task Force. We have quite a full agenda today, so we will officially call the meeting to order, starting with roll call. Ken Kawamoto?

Kensaku Kawamoto – University of Utah – Co-Chair
I'm here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Steven Lane?

Steven Lane – Sutter Health – Co-Chair
Present.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Anil Jain?

Anil Jain – IBM Watson Health – ISP Task Force Member
I'm here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Arien Malec? Not yet? Andy Truscott?

Andrew Truscott – Accenture – ISP Task Force Member
Present.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer

Hello. Clem McDonald?

Clement McDonald – National Library of Medicine – ISP Task Force Member
Present.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Thank you. Cynthia Fisher? Not yet? David McCallie?

David McCallie – Cerner – ISP Task Force Member
Here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Edward Juhn?

Edward Juhn – Blue Shield of California – ISP Task Force Member
Present.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Terry O'Malley?

Terrence O'Malley – Massachusetts General Hospital – ISP Task Force Member
Here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Les Lenert? Not yet? Jack Po?

Ming Jack Po – Google – ISP Task Force Member
Here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Raj Ratwani? No Raj yet? Okay, Ram Sriram? Not yet. Ricky Bloomfield?

Ricky Bloomfield – Apple – ISP Task Force Member
I'm here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Sasha TerMaat?

Sasha TerMaat – EPIC – ISP Task Force Member
Hello.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Scott Weingarten?

Scott Weingarten – Cedars-Sinai and Stanson Health – ISP Task Force Member
Here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Thank you. Tamer Fakhouri? Not yet. Tina Esposito?

Tina Esposito – Advocate Health Care – ISP Task Force Member
Present.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Valerie Grey?

Valerie Grey – New York eHealth Collaborative – ISP Task Force Member
Present.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
And, Victor Lee. Okay, we'll circle back to those who may be running a few minutes late. So, we are fortunate enough to be joined by our national coordinator, Dr. Rucker, and I will turn it over to him for a few opening remarks.

Donald Rucker – Office of the National Coordinator for Health Information Technology – National Coordinator
Thanks, Lauren. We'll keep this part quick. First of all, I just wanted to thank everybody for the major effort of participating in this committee. As folks know, standards work is a bit of an acquired taste. It may have come naturally to Clem, but for the rest of us, it's an acquired taste, and it's a lot of work, but it's absolutely critical to getting this done. Obviously, the task force is looking at a roughly 15-month overall time spend here to do this. It's something that was called out by Congress. In large part, I think our deliverable is the Interoperability Standards Advisory document, but anything surrounding is there as well. So, I just want to thank everybody for putting in the hard work on that, and we look forward to that.

I have two announcements. One is a bit of very exciting news that I think most folks know, but roughly two weeks ago, the physician fee schedule – we put out a proposal for a blended payment rate for the office E&M codes. One of the biggest problems with electronic medical records is the vastness of the boilerplate text that is in those records. I want to give a shout-out to Sasha and her colleagues at EPIC for nicely documenting. As in the *Annals* op-ed by some of the folks earlier this month, 4,000 characters for an average ambulatory note versus 1,000 – is that what you guys found?

Sasha TerMaat – EPIC – ISP Task Force Member
Oh, I don't remember the numbers offhand, but it was different.

Donald Rucker – Office of the National Coordinator for Health Information Technology – National Coordinator

It's pretty striking. This has also engaged over time if you actually look at some of the other statistics. So, it's open for public comment. We invite public comment on that, but we think this may be a big move to making electronic medical records a more tractable proposition, especially with the 21st-century Cures Act making these notes available to the public as the rulemaking actually comes out of that. Before, I think that stuff was a little bit of a wink and a nod in terms of the providers and the payers understanding the nature of the boilerplate text, but the public is not going to understand that, so in a modern computing environment, we feel this may be a very big advance, but we do invite everybody's public comment on that, which I believe is due September 10th.

The other thing is that we have our second annual Interoperability Forum next week, the afternoon of the August 6th through the afternoon of the 8th. I know a number of folks on the call here are participating in that, and we want to thank you for that. We're pretty excited. I've had a chance to plow through the overall agenda and the various track agendas, and it's looking pretty good. So, we look forward to that in person, and again, just wanted to thank you, and especially wanted to thank Steven and Ken for their work in sharing this. Let me hand it over to Beth.

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
Thanks, Don. If we can go forward a few slides…

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Sorry, Beth, before you start, I just wanted to check in with Steven and Ken to see if they had any additional opening remarks before we get started.

Steven Lane – Sutter Health – Co-Chair
Thanks so much, Lauren, and thanks, Beth, for your readiness. This is Steven Lane. I just wanted to also add my welcome to everyone and thank you all for your ongoing participation. We just had great attendance today. I did want to take a moment to just review the homework a little bit. All of you were invited to spend some time reviewing the Interoperability Standards Advisory, which Dr. Rucker just made reference to. I think if you had a chance to do that, you found a lot of very valuable content there. There are a couple things I wanted to point out. Brett Andreesen is here if we have any questions about that. One thing I wanted to highlight is that everyone has the opportunity to create a personal account on the ISA site and to receive email notifications of changes that occur there, and if you're on this work group, you might want to do that.

Also linked on the site is a related site called the Interoperability Proving Ground, or IPG, which has 410 specific projects listed on it that folks around the country have undertaken or are ongoing in order to test these standards, and I think there's a lot of very valuable information there. Finally, I wanted to point out that in Section 6, under "Questions and Requests for Stakeholder Feedback," there are a number of comments that have been submitted over the last year and a half from very thoughtful commenters from organizations such as the EHRA, HIMSS, IHE, and FEMA, and I think that as we are all deepening our understanding of this space and the work that we're going to be doing here, it could also be valuable to go through and review some of those. I just wanted to point that out if anyone has

any questions for Brett or comments about the ISA or the IPG content that you reviewed. Hearing none, that's great. Thank you, Brett, for taking the time to join us.

And then, Beth, just by way of introduction, I wanted to thank you for coming and preparing these materials to share with the group. You'll all recall that last time we spoke, we discussed the various priorities that are laid out in 21st Century Cures that are going to be orienting our work on this task force, and the first of those priorities was that we were interested in priority uses of health IT that arose from the implementation of incentive programs for the meaningful use of certified EHR technologies, the merit-based incentive payment system alternative payment models, and the hospital value-based purchasing program, so there's a lot to unpack there, and there a lot of situations where the government had seen fit to ask us to utilize certified EHR technology, and Beth is here to put all that together to us to help orient us to the work that we have to do. Ken, do you have anything you want to add?

Kensaku Kawamoto – University of Utah – Co-Chair
No. We're going to get into good discussion in the meet on priorities today, so I'm looking forward to that discussion.

Steven Lane – Sutter Health – Co-Chair
Great. Let's proceed, then.

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
So, that was an excellent segue. Could we move to the next slide? My name is Elisabeth Myers. Some of you probably know me already, and some may not, but I am the Deputy Director of the Office of Policy at ONC. I also used to work at CMS on some of these program, so I've actually worked on them from both ends. So, picking up from the segues there that talked about the priorities, we wanted to just toss this back in here for you as a reference point, and we can come back to this during discussion as well to remind people of each of the pieces we're talking about.

But, this is the actual text from the law that outlines what the identification of the specific priorities actually is, so I'm going to dig in a little bit on the little Romanesque "I" there. It's fairly small on my screen, but it's what was just stated a moment earlier, about one of the priorities being looking at priorities cases that arise from the implementation of health IT within these various programs. Broadly speaking, the CMS programs cover a fairly wide range of provider settings, but it's predominantly – what we're going to talk about a little bit today is meaningful users because that's historically what has set the context that other programs reference at CMS when they're talking about what types of tech are used. So, we're going to mostly focus on the "meaningful user" space, which is now the "promoting interoperability" space. Can we move to the next slide?

So, I realize this is an oversimplification, but we've found this particular – it's not quite a Venn diagram, but a descending circle diagram, I suppose – useful to help folks who are not in the tech space understand what we mean by these various different terms that we use when we're looking at

regulations and laws that say, “We’re talking about this health IT, we’re talking about certified health IT, we’re talking about the certified EHR technology.”

So, health IT is obviously a hugely broad space. Certified health IT modules are actually what ONC certifies within our program. We used to have a different construct to the program, and over time, it’s evolved, and where it has evolved to is to look at standards and sanctions as packages that relate to specific use cases or to a specific standard implementation, and so, you could actually theoretically come in and purchase a different module for every single function that you wanted from a different product. Obviously, most of the products that it comes through do have some sort of packaging of these things to create a baseline set, but overarchingly, the way our program looks at them is as individual certified health IT modules that allow for there to be a flexible implementation of different standards and different ways.

The CMS definition that is used for CMS programs is the nickname CEHRT, Certified EHR Technology, but there’s a difference in terminology that is used between what ONC looks at in our programs and what CMS is looking at in their programs. So, obviously, in EHR, there’s a subset of health information technology that serves in a clinical setting to meet a number of clinical and administrative needs within that setting. What CMS has defined in their CEHRT definition is a specific package of the technology modules in the ONC program that are required for use in those CMS programs.

So, essentially, ONC is setting the standards that developers need to follow; CMS is setting the “When you do these behavioral actions within our program, you need to use technology that is including this, this, and this piece.” Broadly, the CEHRT definition lines up fairly closely with what we call the “base EHR” definition, which is a little confusing, but basically, the ONC EHR definition is our baseline set of requirements that are the minimum to meet a qualified EHR if we’re talking about an EHR package, so broadly, those two things are fairly correlated. There are a few things in the certified EHR technology definition that are specific to meeting CMS programs. Let’s move to the next slide.

So, there are two ways of looking at it, and I tossed this slide in here because I think this might be a useful resource as you’re doing your homework in addition to looking at the ISA. We created a large infographic – it’s quite extensive – that covers all of the 2015 edition, and it covers all of the various functionalities as they relate broadly to a clinical priority, like care coordination, clinical quality measurement, patient engagement, electronic prescribing – these types of things are all defined within a clinical construct. You can also crosswalk these to different program requirements.

So, there are two ways to look at it because of what we were talking about on the previous slide. There’s the specific package within the CMS CEHRT definition, but hopefully, no one is just buying an EHR for the sole purpose of reporting to CMS. Each of the things that are included within that are tied to a behavior for the CMS program, but they’re also broadly tied to clinical priorities that providers are implementing for their own clinical practice improvement or for their own clinical processes. So, this provides a foil to looking at it just by the CMS program requirements, and looking at the two in tandem can help to crosswalk what the broader clinical priority is and how it relates to the CMS behavioral priority so we’re understanding where the standards fit in terms of an actual clinical workflow. Next slide, please.

So, the certified health IT provisions that are adopted through a number of CMS programs – and, this is just a list here, and I should probably caveat this. A few of these slides are going to look a little bit old. They're from things you might have seen in proposed rules, but I do want to make it very clear that anything that is in here is based on final rules from CMS, so we are prohibited from interpreting or making guesses on what CMS might be putting into future final rules based on things that have been currently proposed. So, what you'll see here is a little bit constrained to what has been in prior final rules, and if you do have any questions that actually relate to the CMS policies on the behavioral side, we have colleagues at CMS that we work with on a daily basis with whom we can connect you and get some of those questions answered as well, but I wanted to set out the context here.

So, obviously, the Medicare and Medicaid Promoting Interoperability program previously has been referred to as the EHR Incentive Program, and, historically going back to 2011, has been the path by which CMS has required providers to adopt an EHR to participate in doing certain activities. In Stage 1, you were really looking at data capture and certain standards, and over time, that has evolved to including things like health information exchange, patient access to records, and various types of clinical decision support. So, over time, for eligible clinicians and eligible professionals, that was roped into what is called the Medicare Quality Payment program and Merit-Based Incentive program. We're going to spend a little bit more time on that because it does help to provide some overall context for what CMS is looking at within their different programs, but there are a couple of other things that do reference health IT. I want to point out the CPC Plus Alternative Payment Model and others. There are a number of CMS alternate payment models that do have tech requirements.

The thing to keep in mind for each of the CMS programs at the current point – CMS has worked fairly hard over the years to try and make sure that each new program that is adopting a requirement that there needs to be a technological component to support the behavioral actions for programs – they have aligned and used the same definition. So, essentially, even though there might be different program requirements for a Medicaid hospital than for an eligible clinician in MBIPS, the overarching definition of what goes into their technology package is aligned, so it's aligned to the same ONC modules – in others, obviously, there's slight variations for certain things. In hospitals, how the computer will provide reorder entry is done, and there are a couple of small details like that, but generally speaking, the overarching definition is the same.

They did that deliberately because of the transition space that they see people to be in, where primary care providers and hospitals may be fairly far along adoption, but across the rest of the care continuum, adoption may be lagging depending on what space you're in. If you have relationships with certain medical facilities, you might have better adoption. So, they have tried to keep that package universal to make it a little bit easier for providers who are meeting multiple requirements in multiple programs. Go to the next slide, please.

Very quickly, the reason I want to focus on the Merit-Based Incentive Payment System – the quality payment program itself – is because this particular program includes some references to technology that are where CMS has recently made some changes in terms of how they're focusing on what types of technology they're looking for. So, in the Merit-Based Incentive program in last year's final rule, CMS

did put forward that the 2015 edition would be what is required beginning next year – so, in program year 2019 – and in that program, a number of previous Medicare programs were combined through the MACRA Act several years ago. So, it combined the value-based purchasing program for eligible professionals and eligible clinician, it combined what was called the Physician Quality Reporting system, so that was the prior quality reporting program for doctors, and it combined what was the EHR incentive program for doctors or eligible professionals.

So, those things were put together into one program, and the way that it works is that there's a scoring system established to determine what your positive or negative payment adjustment would be depending on how you report measures for each of these categories. Now, I want to point out the Improvement Activities category is fairly new, and that's been a space where CMS has been trying to be fairly flexible in including clinical practice improvement activities that relate to a fairly wide range of practice settings. Next slide, please. My connection is timing out, but if we're on the next slide, I'll just keep talking.

Steven Lane – Sutter Health – Co-Chair
We are.

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
Okay, great. So, on this slide, you should be looking at something that has four corners divided out. Some of you have probably seen this more than once recently, but this is outlining how tech is referenced in the different sections of the quality payment program, and the reason I wanted to put this up is because this is sort of a microcosm of how text is referenced in CMS programs overall. So, the ACI category – that is, the promoting interoperability piece – is the former "meaningful use." Within that, there is a requirement that you must use certified EHR technology meeting that baseline definition to participate in that section of the program.

So, it has pieces that relate to closing health IT referral loops, it looks at providing patients access to their record, it looks at incentivizing public health and population health reporting, so that is going to look familiar to some of the historical EHR incentive programs, but it has changed over time from "Get a standard and make sure you're capturing the data element in that standard" to using clinical things like clinical decision supports to moving toward more dynamic health information exchange. It's looking at how systems can promote and develop an interoperable infrastructure and use it to improve care.

So, health IT and quality – we're on the other corner there in purple – looks at electronic quality reporting for physicians. Back from my other slide, you'll have noticed that there is a hospital quality reporting program as well. It uses the same definition of certified EHR technology as the baseline. There are differences between what is certified for the hospital quality measures and the quality measures that are used in the quality payment program because their setting base and certification for those measures is specific to the specific ECQM. So, in the quality payment program, there is an end-

to-end electronic reporting piece to the Quality category, and that allows for some pretty wide flexibility.

So, it does allow a clinician to get points for their score in that category based on reporting and electronic clinical quality measures that is one of the CMS electronic clinical quality measures, but one of the other interesting things that CMS did that I think is sort of important to look at is how they're trying to work from a behavioral side and use from the tech side to look broader than what they've defined in what their electronic clinical quality measure is looking at, how there are other electronic clinical quality measures – maybe it's a registry measure, and that registry has electronically specified their measure, and they are, in fact, using standardized data elements that you can get credit for your electronic reporting bonus if you're using that certified tech that has those data elements standardized in it to report something beyond what the CMS electronic clinical quality measure is.

So, on the hospital side, at this point in time, they're still restrained with the electronic clinical quality measures for the IQR that are CMS-specific, but there are options available that you could potentially leverage tech for some of the other reporting. So, I'm going to point out two other things on this slide and then go quickly to a little bit more detail on what is currently required for those specific "promoting interoperability" or "meaningful use" action.

To help IT improvement activities, CMS had developed a category – or, sort of a subcategory – of improvement activities in the "clinical practice improving activity" section of their MBIPS program that included references to technology and how it could be used to implement those clinical practice improvement activities. So, there's actually a fairly significant number of them that specifically reference the use of certified EHR technology for implementing that improvement activity. I think there are 30-sometehing of them at this point in time.

For awareness, that doesn't mean they have to be done using that, but it's trying to put forward the information that providers might find useful to understand how their clinical practice improvement activity can be supported by technology that is currently existing in the industry. So, if it is something to manage diabetes, there are ways to look at using patient-specific education and patient access to records and care coordination to help support that clinical practice improvement activity that you might be doing that might be tied to a specific use case or a specific population.

And, the last thing I want to point out is health IT and APMs. APMs are the alternate payment models. There are specific alternate payment models that are included in the quality payment program. For each of those, the standard CMS originally adopted was that at least 50 percent of clinicians in that advanced alternate payment model must use certified EHR technology. Again, this is the same definition of that package of certified EHR technologies – so, it's the same package of functions and standards from the ONC program that has to be used. The difference is that in an alternate payment model, the model itself is defining if there are additional certified health IT modules that might have to be part of it.

For example, if you were to look at a care plan, which is another option that we have in certification programs that is beyond the CEHRT definition, looking at things like how to filter electronic clinical

quality measures down to different use cases, those things are defined by the model, and the model also defines what it means to be a user of that technology within the construct of the model. So, it's a little bit different than having a broad-scope CMS program, and that implementation is specific to the models. Next slide, please.

So, I'm hoping – I still can't see, so I'm hoping that we are on the slide that has the boxes that say what is in…okay. So, there's an error on this, but I will point that out as we get there. I thought I had provided the one that was updated, and I apologize for that. So, there are six categories of specific things that are part of the Advancing Care Information category, the Promoting Interoperability category for meaningful use for the Merit-Based Incentive Program. They're protecting patient health information – that is, performing a security risk analysis consistent with the HIPAA security rules. Electronic prescribing – I wanna point that one out in particular. That one is a requirement of the HITAC Act, so it is a part of the program that is required for all participants that are doing meaningful use.

The patient electronic access – that includes the provision of access to a patient in using the 2015 edition for 2019. That does mean using the API that is currently in the 2015 edition. So, it is looking at providing access to view, download, transmit, and provide patient access through an API, and that's a really important distinction. All four actions are required to be accomplished, not that you can choose to just do a patient portal or just do the API. You actually have to provide all four actions. Now, if your API solution also allows for the view, download, and transmit, then you can do it in that way that things sort of overlap, but it's essentially requiring that all four actions are completed, and then using the 2015 edition to do so.

Care coordination through patient engagement – that includes things like secure messaging, patient-specific education, a PGHD capture, which is actually using a sort of open capture certification criterion to allow for patient-generated information – patient health data capture – to be incorporated into an EHR. And then, there's the health information exchange, which includes both the transmission of a summary-of-care record, but also, the ability to receive, incorporate, and reconcile information from that record.

And then, finally, public health reporting and clinical data registry reporting – this includes immunization reporting. There is the ability to use PDMP reporting to get credit for a measure within that category, and it includes things like specialized registries as well. So, it's sort of a snapshot of the primary areas of focus for CMS right now for these programs. Obviously, again, my disclaimer is that there have been proposed rules, so CMS is looking at changing things over time, but until such things are finalized, this is how we have to refer and think about the construct of where the current state is for the CMS programs.

So, that is the end of my slides. I think we do have about six minutes available for questions. So, if there are any questions on anything here, I know this is a bit of an overarching overview, but I wanted to mostly emphasize and reiterate what the interplay is between our certification program and the standards that we're looking at and how they become part of a package that providers are required to use. So, I will pause if there are any questions.

Terrence O'Malley – Massachusetts General Hospital – ISP Task Force Member
Beth, this is Terry O'Malley. Focusing on the eligible providers obviously makes a lot of sense because that's where the focus has been for so long. There seem to be some pathways to the farther reaches of the healthcare continuum of ones that aren't using certified EHR technology, and I'm just wondering if there is a roadmap for pushing this out to home- and community-based services. Is the EHR technology used in skilled nursing facilities and home health certified, or going to be?

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
Yes, that's an excellent question. I have a couple points to that question. From the concept of whether there's a home health certification or NEP certification or a hospital certification – so, this is why I think this line difference between how the two programs interplay is really important. At ONC, we try to think about the certification program as being a floor, and we're trying to make it a floor that as many people as possible can build on. We actually don't see the program – and, this has been a deliberate effort over time to make the program more in this manner. Originally, it was largely to support the meaningful user in the 2011 program, but we see the need to be looking at standards for broad use cases that fit multiple settings. So, it's attempting to try and address things that can be fairly setting-agnostic, like the ability to exchange a record, the ability to capture a certain thing in a certain link code, and so forth.

CMS – there isn't an incentive program for people beyond the meaningful users or the hospitals, so there's the eligible professionals in the hospitals. There are folks who are looking at alternate payment models that include a wider range of **[inaudible] [00:34:33]**. There are also alternate payment models that look specifically at specialties within some of the settings that we've been talking about, so there are some interesting things coming up that look at pediatric care, or how long-term post-acute care is incorporated into an overarching health system package that is part of an overarching alternate payment model. So, they're definitely looking at it and those conversations are happening. There's also interesting work being done in the long-term post-acute care programs at CMS. I think there might be some folks that you'd actually want to talk to, so we can get them available for you, but there aren't specific requirements at this point in time that are regulatory program requirements beyond this current space that we're talking about.

So, the discussions are definitely happening, both in how to make sure that there aren't care settings that are just left behind the technology race, but also, making sure that as the transition happens – as SNIS and long-term post-acute care facilities move to adopt technology, which a fairly significant number of them are, how are we ensuring that that is integrated and that the data that is needed to move from one setting to another can do so, and we don't have data graveyards? So, we're definitely thinking about it from the integration side, and CMS is definitely looking at it through the pieces or parts of the program that can make it so that there are opportunities for providers who may not be participating in a meaningful use program, but may be connected with CMS in another way to incentivize the adoption of health IT.

Clement McDonald – National Library of Medicine – ISP Task Force Member

Could I ask a question along the same line? We heard a talk today from the Acting Medical Informatics Director of CMS, and she talked about the blue button and the downloadability to patients – and eventually, perhaps, to providers – of the stuff in VRDC, the big database of Medicare. And, I believe that the OASIS data is in there, and I'm not sure, so my question is – which is home healthcare – whether that data is going to be downloadable with a blue button as well. This may be out of your space, but I still wondered.

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
I have to say that those CMS folks are the right ones to talk to about that program in particular. I can say that that we have heard that question before, and there are lots of conversations about if that data is available to more folks, how it will help support care continuums. So, I can give you that much, but it's definitely something that we're thinking about, and we're thinking about that in partnership in CMS, and they are very much thinking about it in terms of getting further detail on the various use cases and settings that they might be thinking about specifically. We'd have to refer you to CMS, but we can get some folks to help with that.

Clement McDonald – National Library of Medicine – ISP Task Force Member
To encourage Terry, we recently had a connection with a big home healthcare unit in Georgia who's going to use FHIR and the standard CMS codes for the OASIS codes to deliver them to CMS, so standards are coming there.

David McCallie – Cerner – ISP Task Force Member
Can you hear me? This is David McCallie.

Steven Lane – Sutter Health – Co-Chair
Yeah, we can hear you, thank you. This is Steven Lane, and I wanted to give you a chance to speak. I wanted to thank both Terry and Clem for your comments and highlight the fact that Dave very appropriately raised his hand using the hand-raising function in Adobe Connect, and we're going to try to rely on that. So, thank you, David. Go ahead.

David McCallie – Cerner – ISP Task Force Member
I'm not trying to be pushy. I was worried that I wasn't connected through because I had trouble earlier and I somehow was in listen-only mode. So, I apologize for being pushy, but you trained me well on the hand-raising mechanism. But, my question is in the other direction, which is if this priorities task force identifies a new use case and a new standard to use, what's the process by which that actually becomes relevant to these incentive programs? Does it have to become part of a subsequent edition of Certified EHR Technology, and what would that process and timeline look like? Does that make sense as a question, Elisabeth?

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
It does. I think that there's a question of scope, so we want to be a little cautious about scope with this task force, that the concept with what the law says about prioritizing use cases for the implementation

of the program doesn't really say that we should tell the programs what to do, so we have to be a little cautious there, but essentially, the CMS team has a call for measures for clinical quality measures that goes through the NQF process every year, they have done calls for improvement activities for incorporation into the Merit-Based Inceptive Program, they've done calls for meaningful use measures in the past, and I think they're considering how these things might be more interconnected instead of separate going forward.

So, there's definitely space for public input to CMS about what they should be considering and looking at beyond whether they commented on the proposed rule. Then, there is also always the opportunity to put in public comment on a proposed rule. The thing to keep in mind is that it does take time for them to work through those things and make sure that they're implementable for a wider range of people because they certainly don't want to require something that isn't feasible.

From our end, the things like the work that we're doing around the Interoperability Standards Advisory and the types of information that we get back from you all will inform our policymaking decisions about how our program evolves over time and the way that prioritize things that we're looking at over time. So, there are ways to have the idea of saying, "This is a really innovative space that's happening. Should we be looking at adopting this on a wider scale?" There are feedback loops, and we can talk more about those in detail about where to feed those ideas.

David McCallie – Cerner – ISP Task Force Member
Is there a plan to have something – the 2015 edition is 2015-timestamped. Is there a plan to have a 2020 edition, or is that yet to be determined?

Elisabeth Myers – Office of the National Coordinator for Health Information Technology – Deputy Director
The unified agenda for this fall notes an ONC rulemaking, and that is to implement the provisions of the Cures Act – the ones that are ONC-oriented, I should say, because obviously, the Cures Act is huge. So, there are some pieces of the Cures Act that direct ONC – for example, this new version of the FACA, some of the work on burden reduction in 4001, the conditions of certification, the trust exchange framework – that give us an opportunity to rethink how we're looking at things. So, I can say stay tuned, and there may be more information provided to give you some context of what we're looking at at the time that the rulemaking that's identified in the unified agenda is made available.

David McCallie – Cerner – ISP Task Force Member
Thanks.

Steven Lane – Sutter Health – Co-Chair
Thank you so much, Elisabeth. I really appreciate your presentation and the questions you took. Arien, we can see that your hand is up. I think we're going to cut off questions here and move on to the rest of our agenda. We have just about 30 minutes now before we transition to public comments, and we wanted to use this time for diving down into our priority uses. So, if no one objects, we're going to go ahead and do that. What we'll do is switch over the screen, and Ken is now displaying a version of the use matrix that we shared briefly at the end of the last meeting, and we're going to use this to collect

your thoughts in particular about these priority categories that were specified in 21st Century Cures that we just reviewed with Beth's help and try to start collecting ideas about what's important about these categories, what sorts of uses we see as critical and falling under these categories, and just collecting comments and insights.

What we'd really like to do – Ken's highlighting the fact that we added one at the end regarding infrastructure to the nine that were laid out in the regulation, and what we're hoping to do during the next half hour as well as probably during some time in our next couple of meetings is really dig down into these priorities and get your insights, remembering that we've collected a very broad group of stakeholders onto the task force; we also have the public listening in, and there will be time for public comment at the end before we start digging down into the details of the priority uses themselves, really understanding these categories.

Before we start, I just wanted to make one other comment that I'd neglected to make at the front end, which is that the detailed notes from our meetings are prepared at the end of each meeting. Ken and I work with the ONC staff to finalize those, and those are posted to the HITAC portal, and all of the members of the task force do have access to that portal. Our understanding is that all of you have set up your accounts and made that work for yourselves. So, the way that the FACA task forces work is the detailed notes are not made part of the general public record, but are made available to the task force, whereas all of the materials from our meetings are made public, and that's not up to any of us, but it is the way it is, and I just want to make sure that everybody was fully aware of that.

So, with that, Ken, can I ask you to orient us to how you envision this part going forward? And then, what we're going to try to do is run down the list of the task force members and give everyone a chance to shout out or provide some input on these priorities, and Ken's going to be getting that down as we go, and then we will try to reorganize that and bring it back next time.

Kensaku Kawamoto – University of Utah – Co-Chair
Absolutely. So, we thought of different ways of doing this. We thought probably the easiest and most productive way to do this is to just lay out what the focus for 21st Century Cures Act is for priority categories, including this notion of cross-cutting infrastructure. So, if you have things that you think are related to a variety of different aspects of health IT, we can put it there, but really, we're just going to go around and get your thoughts on what priority use is.

After we get all those thoughts over the next several meetings, we can get into different potential ways to further classify, group, or organize our thoughts, but basically, this is a brainstorming session where you bring up the things that are top of mind, and if you're focused on research, we can go right into your research priority. If it's on public health, we can go there. If it's on cross-country infrastructure, we can do that. So, that's the idea. I'll live edit while we're going. As we're commenting, if you see that I'm noting your thought differently from how you want it expressed, let me know and I'll correct that.

Steven Lane – Sutter Health – Co-Chair

I think that realistically, if we get through one round of this today with all the task force members, that will be a job well done, and I think that in the future, we'll start going a little bit quicker. And, Clem, I see your hand up, but I think – why don't you go ahead and make your comment, and then we'll start the round with Andy?

Clement McDonald – National Library of Medicine – ISP Task Force Member
Well, I'm just not crystal clear on how to think about this. You can't use any data unless you get it, and I think we still have problems with that, so I'm not sure what's – I just can't get my head around what we're trying to get to.

Steven Lane – Sutter Health – Co-Chair
I think that it – go ahead, Ken.

Kensaku Kawamoto – University of Utah – Co-Chair
Clem, here's the big picture: The notion is that we identify priority uses as well as the standards and technology needed. Now, when you say we don't have this data, I think you probably have certain use cases in mind, but if it's something around infrastructure needs – say this particular type of data that you think is important is in the record, but we don't pull out, or we pull out in different ways, or it's stored in different ways, captured in different ways – I think that would go under "infrastructure" because that's highly likely to be classifying. To put it another way, whatever you think is the most important thing we need to deal with in this area, I think we can figure out where to put it in this matrix because as a catchall, we have "infrastructure."

Clement McDonald – National Library of Medicine – ISP Task Force Member
Well, we started out at the beginning of the year with a list of classes of data that might be good to get, and I guess these don't connect at all, but I'm at a loss to know what data we think we're going to have access to, or is this the way to decide what data we should have access to?

Steven Lane – Sutter Health – Co-Chair
Clem, I think that what we really wanted to do is to start by getting people's ideas about the priorities themselves that were laid out in the law. Again, the notion of infrastructure is an add-on. It wasn't called for by regulation, so we're creating it as another place to put some ideas, but we want to dive in and get people's thoughts and questions. I think your question is well put, and maybe Ken, you can get that down, but the notion of access to data is clearly a key issue for all of these. Again, these are the priorities that we were asked to evaluate by the regulation.

So, we just want to get people's ideas out about the categories before we dive too deeply into the uses themselves, and then the prioritization of those uses. So, let's just give it a shot. Again, I see hands up, but what I want to do is give everyone a chance to talk. Sasha, if you can just hold that thought, we're going to try this. Thank you. So, Andy Truscott, you were unable to join us time, so welcome to the group. Do you have any general thoughts about these priorities as laid out in regulation and how we might orient ourselves to them? Andy Truscott, if you're speaking, you are on mute. If you don't have anything to add, that's totally fine too.

Andrew Truscott – Accenture – ISP Task Force Member
Hi, sorry about that. I was on mute. I'm good with this. I think this is a good, considered series of focus areas, and I think we're going to probably elucidate more as we go forward, and I think some of the priorities are going to emerge as we work forwards with this group. I think something else that's going to come out as well is going to be how we would consider realizing the priorities in the minds of those who'll be consuming the use cases and the standards and how we can help assure adherence to the standards as they go through. I think those are going to be emerging themes as we go through this. Good to meet you all, as well. Thank you.

Steven Lane – Sutter Health – Co-Chair
Great. Arien? We might have some trouble getting people off of mute in time here. Arien Malec? Great, we can come back. I know you had your hand up earlier. Let's see. I think Carolyn is the next task force member in line. I'm going alphabetically by first name, so if I omit somebody, please stop me.

Arien Malec – Change Healthcare – ISP Task Force Member
Can you hear me now?

Steven Lane – Sutter Health – Co-Chair
There you are. Arien, you're back.

Arien Malec – Change Healthcare – ISP Task Force Member
Yeah. I don't know what's going on with the technology, but anyway, here we are. So, I think this is a pretty good list of potential uses. I do think we're going to need to prioritize, but I can anticipate that almost all the things that we're going to come up with will fit one of these slots, so I think it's a good organizational structure, but as I said, my point is that we're at some point where we're going to need to create a more focused, prioritized list because to make progress through interoperability, you need to pick a few bullets and aim carefully.

Steven Lane – Sutter Health – Co-Chair
Great. Let's see. Next up is going to be Cynthia Fisher – no, Clem. I'm sorry. I'm trying to keep the…

Clement McDonald – National Library of Medicine – ISP Task Force Member
I've already –

Steven Lane – Sutter Health – Co-Chair
You've already commented?

Clement McDonald – National Library of Medicine – ISP Task Force Member
Yeah, just listening to get a better sense of it.

Steven Lane – Sutter Health – Co-Chair

All right. This is tricky because I'm trying to make sure that I capture the members of the task force and not others.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Steven, this is Lauren.

Steven Lane – Sutter Health – Co-Chair
Can you guys run the lists?

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Yeah, I can do it from the attendance list. So, I'm going to go back to the top and start with Anil Jain.

Steven Lane – Sutter Health – Co-Chair
I didn't see him on the call, but that's right, he may be just audio only.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. I just got a note. He said he had to drop off a few minutes early. We're going to jump down to Cynthia Fisher.

Cynthia Fisher – WaterRev, LLC – ISP Task Force Member
Yes, this is she. I'm fine with what has been presented thus far. I do think it would be helpful perhaps to have some discussion on the side that takes a patient's perspective and a caregiver's perspective on prioritization. **[Inaudible] [00:54:58]**

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
I'm not sure if we caught that. It was breaking up on my end.

Steven Lane – Sutter Health – Co-Chair
It was, but I think this was a comment.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
All right. Did you capture Cynthia's comment, or should we try to clarify?

Steven Lane – Sutter Health – Co-Chair
I think I did. I'm pretty sure this was the comment.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
All right. David McCallie?

David McCallie – Cerner – ISP Task Force Member
Yes. Can you hear me?

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Yes, we can.

David McCallie – Cerner – ISP Task Force Member
Good. So, my understanding of what you were asking us to do was take this given list that's defined in the Cures legislation and start to flesh out some specific uses. Maybe I misunderstood the instruction.

Kensaku Kawamoto – University of Utah – Co-Chair
Are there any comments that you might have regarding the priorities themselves, clarifications that you want to add, or clarifications that you'd like to get from ONC or others just to orient us to the work ahead?

David McCallie – Cerner – ISP Task Force Member
Right, but the list itself is from Cures, so it's not a list that we have a lot of choice in expanding or collapsing, if I understand it.

Kensaku Kawamoto – University of Utah – Co-Chair
Correct. We just need to understand it.

David McCallie – Cerner – ISP Task Force Member
Okay. Well, it's a broad list, and certainly enough to keep us busy for a long time. I have some specific things in each category. For example, in Patient Safety, I think we need to standardize ways to report out safety issues in a consistent, standardized way that respects the patient's privacy, but at the same time, captures the context for a near miss. I think in Individual Access, we've got to start with the read-only APIs of the 2015 edition. Quickly, consumers are going to be able to do other things in a standardized way, such as make appointments and send secure messages to and from their clinicians, so I think we could radically expand the capabilities for patient access through the APIs.

On Research, I think the plethora of different research export formats that we have to deal with in the vendor community should be coalesced around a standard FHIR-based research export format that can then be transformed into the shape that's needed by a specific research community. I think we could make progress in that space. I think there's a broad infrastructure need to better define how we do structured reporting. We have made a couple of passes in the standards community around the ability to capture data for registries, for example, where you sometimes need quite detailed data, maybe more detailed than is typically captured in the EHR's normal workflow. So, how do you introduce that structured reporting?

Kensaku Kawamoto – University of Utah – Co-Chair
David, could you repeat that last one? Under which category?

David McCallie – Cerner – ISP Task Force Member
Sure. Maybe it's more infrastructure. I'm not sure where it fits, but Ken, I'd be happy to write these up and send them to you offline. The registry reporting needs a standardized way so that the hundreds of different registries that want data out of the EHR workflow could do it in a consistent, standardized fashion. I guess registries are an upstream feed for clinical research, so maybe this would fall under the clinical research category, but as it is now, it's custom work for every new registry, and that's not a

sustainable approach. There are a number of projects underway to try to get some consistency there – the ACC, the cardiologists have a massive effort to harmonize the way they do it, but it needs to affect all the registries. Does that make sense?

Kensaku Kawamoto – University of Utah – Co-Chair
Yes.

David McCallie – Cerner – ISP Task Force Member
And then, on the innovations and HIT space, I think we have a good start with smart apps and CDS hooks, but those are still obviously fairly immature, so I'd expect that we could expand the support for the ability to create plugins that allow for innovative companies to interject their products into the clinical workflow. In other words, innovations need a way to get onto the desktop of the providers, and smart apps and CDS hooks are a start, but we've got a lot more work to do there. Ken, you certainly understand those two comments.

Kensaku Kawamoto – University of Utah – Co-Chair
Yeah, and I just realized that Google Docs doesn't respell "EHRs" as "HERs," so I'm very appreciative of that.

David McCallie – Cerner – ISP Task Force Member
Innovation.

Kensaku Kawamoto – University of Utah – Co-Chair
David, thank you for all those comments.

David McCallie – Cerner – ISP Task Force Member
Yeah, I'll stop there. I've used up my airtime.

Steven Lane – Sutter Health – Co-Chair
Terry, I see your hand is up. Do you feel like you need to get in now, or can you wait until we get to you in the sequence?

Terrence O'Malley – Massachusetts General Hospital – ISP Task Force Member
No, I can wait.

Kensaku Kawamoto – University of Utah – Co-Chair
Okay, great. Thanks.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Almost there, Terry. First, Edward.

Edward Juhn – Blue Shield of California – ISP Task Force Member
Hi. Can you hear me?

Kensaku Kawamoto – University of Utah – Co-Chair
Yes.

Edward Juhn – Blue Shield of California – ISP Task Force Member
Great. I agree with what was mentioned earlier, and another general thought is as we begin looking into the various priority uses and various statutory categories or new standards, would it be helpful in also addressing how each of these would impact broader fields, such as population health, public health, community health, or individual health, or addressing how each of these priority uses, statutory categories, or new standards would impact the needs of the healthcare system, for example, versus the needs of the public or the needs of the caretaker, as somebody had mentioned earlier?

Kensaku Kawamoto – University of Utah – Co-Chair
Okay.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Was that it, Edward?

Edward Juhn – Blue Shield of California – ISP Task Force Member
Yes, those are all of mine.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay, thanks. Terry?

Terrence O'Malley – Massachusetts General Hospital – ISP Task Force Member
Sure. I just have a couple comments. The connection with the USCDI work – and, this is obviously very strong – one of the issues we brought up with the USCDI is the need for specific use cases to help focus us on not only the data, but also the process, the uses to which it's going to be put, and the customers who want it. So, at some point, we might want to think about specific use cases. That's just one comment. Two potential additions – there are a couple of processes that are pretty fundamental, and one that just came to mind was the process of attribution. Now, how do we attribute individuals to clinicians, individuals to payers, and even individuals in specific registries? But, it's the process itself and whether there's a standardized way of doing attribution.

And then, maybe you could let me throw in the comments that I shared with Steven and Ken earlier. In a sense, that's about some cross-cutting issues that really affect all of these categories, and one would be everything around the unambiguous identification of the individual. How do we do that? And then, a related piece is the individual controlling the data. How do they give permission to use it and what are the specific uses, like those listed under TEFCA and others? The mirror issue for the rest of the healthcare system is unambiguous identification of who they are. In a sense, attribution and unambiguous identification are all related. I'll stop there. Thank you.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. I'll just circle back. Do we have Les Lenert on the line?

Leslie Lenert – Medical University of South Carolina – ISP Task Force Member
Yes, I am on now.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay, perfect. Thank you. Did you have any comments?

Leslie Lenert – Medical University of South Carolina – ISP Task Force Member
Yes. I wanted to make one comment specifically about the prioritization tasks. It seems to me that as we're focused – when we can identify different specific tasks that use essentially the same infrastructure, those have to be prioritized. It's great to look at these one at a time for priorities, but what I really like is the idea that we can focus on a set of common methods that allow us to hit three or four of these at the same time. For example, the issues on population health, public health, and research all may have the same standards required for interface. There may be different specifics about the vocabulary – that may change – but the approach for downloading groups of patients and the data on those may be also true for safety as well. If we can find a core across four or five of these areas, that would cause that whole area to be promoted together and to be prioritized together.

Steven Lane – Sutter Health – Co-Chair
Thanks, Les. I also wanted to take the opportunity – I welcomed Dan to his first meeting. Clem, I think we also missed you at our first meeting, and I wanted to officially welcome you to the task force, and Les, you as well. It's great to have all of you here. I'll just say it now: Scott Weingarten also missed us last time, and I think he's with us, at least in spirit, so thank you all. I also wanted to acknowledge for everyone's benefit that Terry O'Malley is one of the co-chairs of the USCDI task force and brings with him a deep knowledge of the work of that group, both past and potentially in the future. So, we've got great representation there. Go ahead, Lauren.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. We'll resume with Jack Po.

Ming Jack Po – Google – ISP Task Force Member
Thanks. I agree with what many of the members have already mentioned. I have a few specific things. I think the ability to have a unique patient ID and a unique provider ID would be really important for a lot of innovation work. The ability to do something that is much more substantial than FHIR or CDS hooks would be really helpful. One thing that would be helpful to add somewhere is some standardization to figure out how to add CPS results, whether it's a model, some sort of output, or some sort of clinical support, some standards around how you would add that data back into either the EHR systems, or registries, or storage systems.

Kensaku Kawamoto – University of Utah – Co-Chair
What was that you were referring to? Predictive model results?

Ming Jack Po – Google – ISP Task Force Member
Yeah, one that is predictive or has some sort of CPS model results. Right now –

Kensaku Kawamoto – University of Utah – Co-Chair
What does CPS stand for? I'm not familiar with that.

Ming Jack Po – Google – ISP Task Force Member
Clinical Patient Support.

Kensaku Kawamoto – University of Utah – Co-Chair
Okay, got it.

Ming Jack Po – Google – ISP Task Force Member
And, the last thing that I would add would be some way to actually standardize the request for either permission or the type of information that these apps are asking for. So, some of us have been thinking about how as meaningful use really comes online, there will be a lot of apps that are made by innovators that are going to start asking for information from providers or health systems and some sort of data on how patients can actually view those requests and keep track of those requests. Otherwise, they're likely to get extremely confused and either give away a lot of information or won't really know how to answer those queries.

Kensaku Kawamoto – University of Utah – Co-Chair
Just to verify, are you talking about patients having a good sense of who has accessed their data? Is that what you're talking about.

Ming Jack Po – Google – ISP Task Force Member
Exactly, some standards around that. Thank you.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. We'll take a couple more before we break for public comment. So, we'll go to Raj. Raj, any comments?

Steven Lane – Sutter Health – Co-Chair
Raj, if you're speaking, you're on mute.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. We can circle back if he had to drop off. Ram, any comments?

Ram Sriram – NIST – ISP Task Force Member
I don't have any comments right now, but I'll send an email.

Steven Lane – Sutter Health – Co-Chair
I think he said that he'd send an email, so we can go to the next now. Thank you.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Great. Ricky Bloomfield

Ricky Bloomfield – Apple – ISP Task Force Member
Sure. I agree with many of the comments that have been made already. I just have a few things to add. One is making sure we look at the issue of financial transparency. I don't know if that would fit under Payment Incentive Programs. CMS has done some work already to require health systems to release some of their fee schedules publicly. To go along with that, real-time benefit check by an API is also an issue that has come up – so, knowing the end user's or the patient's benefits can be used to make better decisions at the point of care. And then, access to claims data, to which, again, CMS has blazed a trail here from a Blue Button 2.0 standpoint, but getting the private payers on board with that as well would be very important from a user's perspective. Also, looking at standardized out comes, a la ICHOM and the work that they've done, making sure that's in broader use. That would probably fall under either Quality Patient Care or Public Health Uses.

Kensaku Kawamoto – University of Utah – Co-Chair
How do you spell ICHOM?

Ricky Bloomfield – Apple – ISP Task Force Member
I-C-H-O-M. And, I'm not saying that we necessarily need to adopt ICHOM, but we should at least look at standardized outcomes in a scalable way so that we can measure these better.

Clement McDonald – National Library of Medicine – ISP Task Force Member
Could someone send the ICHOM stuff around to everybody?

David McCallie – Cerner – ISP Task Force Member
It's on the web.

Ricky Bloomfield – Apple – ISP Task Force Member
Yeah. If you just do a Google search, you'll get their website and have access to everything, but it would be good to add to the notes so that everyone has access to it. There it is.

David McCallie – Cerner – ISP Task Force Member
Very complicated.

Ricky Bloomfield – Apple – ISP Task Force Member
If there are better ways to do that, then I think that's something this group can discuss. It is a complicated thing, especially when you look at international uses. Then, for Ability for Individuals to Access Electronic Health IT, I think that ONC has looked at patient matching a little bit. I'm not sure if the outcomes there were scalable with the competition that happened, so we should look at ways to implement that so we can reduce barriers to access across multiple EHRs and portals.

In general, we should lower the barrier to portal access. Right now, it's very heterogeneous. The requirements across multiple health systems and EHRs – the requirements for users to create a portal, whether it's in-person identity-proofing or remote KBA are mostly based on local policy, so we should discuss that. Also, related to Individual Access, there's been a lot of discussion around directory of FHIR endpoints and making those endpoints more discoverable. There have been suggestions of RSS-feed-

type discoverability there so that when these endpoints are made public by the health system, they can also be easily discovered in an automatic way so that developers have an easy way to understand who has APIs available. Right now, that's difficult and not always public.

And then, from an infrastructure standpoint, we've already raised USCDI. I think we should look at that. One of the items that many folks have said was missing from the Argonaut implementation was consistent application of the Encounter resource – so, having the context for where the information came from and the encounter it was related to, which tends to be, from a consumer perspective, how they group things and think about it, but right now, that's totally missing from Argonaut. Although some EHR vendors have implemented it, it's not yet available in a standardized way.

Kensaku Kawamoto – University of Utah – Co-Chair
Ricky, could you repeat a little bit about the decisions you saw on the Encounter interface again?

Ricky Bloomfield – Apple – ISP Task Force Member
Sure. The Encounter resource is not something that's been implemented via Argonaut, so it's not yet available in a scalable way across EHR vendors, and the Encounter resource is critical from a user standpoint. That's how they tend to group the information that's collected about them related to the clinic visits or the inpatient admission that they had. And so, labs that are done, procedures, et cetera, aren't tied to that encounter in a programmatic way. And then, the other one is provenance of the data. There is a provenance resource in FHIR that's not yet well-utilized, so we can have a better sense of origin of data and editing of data so we can audit that appropriately and understand the lifecycle of the information. Those are just a few things off the top of my head. I can think about it a bit more as well, but it looks like we have a good list started here.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay, thanks, Ricky. I think we'll try to squeeze in one more before we go to public comment. Sasha, you had a comment earlier.

Sasha TerMaat – EPIC – ISP Task Force Member
Sure. I have two areas I would add quickly before we go to public comment. I'm also happy to send more thoughts along via email. My first thought is around quality measurement, which, of course, is very relevant to the federal programs about which Beth started our conversation today, and even within the quality measurement space, there are usability aspects of the data capture and the impact on clinicians, which ties very similarly to some of the registry things that were talked about. There are also questions about submission and transparency of data. For example, clinicians have very little insight into any of the cost measures that are being evaluated on, and I think that becomes a larger and larger component of some of these programs. It's certainly something that's of interest.

The second category that I would like us to add as a priority has to do with the expansion of FHIR apps that folks have been talking about, and it's to standardize how we express the policies and terms of use that different applications will have for a user, and I think that as patients are making choices about which apps they want to connect to their health records and how they want to use those, knowing how the data is stored, further transmitted, the possibility of it being deleted or made public – all those

pieces of data will be of interest, but it's hard when they're buried in a 20-page legalese document to pull out what might be significant in that decision.

Clement McDonald – National Library of Medicine – ISP Task Force Member
This is Clem. I passed my turn. I've just got a short thing to add, if I may.

Steven Lane – Sutter Health – Co-Chair
Go ahead.

Clement McDonald – National Library of Medicine – ISP Task Force Member
I think we've got to remember – I don't know whether this belongs in General or up in Clinical Care, but you've got to remember that one person's burden is another person's boon. I'm specifically thinking about the registries. One of the challenges of the cardiology registry is that it costs hospitals a fortune to collect it because data has cost. And so, to convert it to what the physician has to do in the regular process of care, it's a burden, but it's a boon to the others. So, there are people with no skin in the game. Somehow, we've got to balance the cost and perhaps even demand some high-quality requirements on the data they ask to collect. A lot of these questionnaires just come out of the blue. They're not really validated or anything. So, whenever we think about the stuff we'd like to add, who has to do it, and is it free for the person who wants it and costly for the person who has to do it?

Steven Lane – Sutter Health – Co-Chair
Thanks, Clem, for those comments. I think we're going to stop the round at this point and pick up again at our next meeting because I think it's really valuable for everyone to have a chance to chime in, and we should probably go to public comments now.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Thanks, Steven. Operator, would you please open the public line for comments? Just as a reminder to the public members dialing in, we ask you to keep your comments to three minutes or less, and the phone number is presented on the screen. Operator, do we have the public line open?

Operator
Yes.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Do we have any comments in the queue at this time?

Operator
No comments.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. Hearing no public comments, we'll just give you a few additional seconds. Steven and Ken, would you like to resume the round robin comments, or should we just break and discuss next steps?

Kensaku Kawamoto – University of Utah – Co-Chair

I think we may have time for one more comments. Our understanding is that Scott Weingarten – Scott, are you on the phone? We don't have you down.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
I think we may have dropped Scott. Let me just confirm – operator, no additional public comments, correct?

Operator
Correct.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
All right. After Scott on the list was Tamer. Is Tamer still on the line? Is he coming off his mute?

Ram Sriram – NIST – ISP Task Force Member
Hello? There we go. Thanks. I agree with the previous comments. I feel that the prior use areas are appropriate. I wanted to second some of the comments about benefit checking being an area to look into, as well as under innovation, more robust integration into the EHR with third-party apps and services, and also, discussing the standards around outcome reporting. That's all.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Great, thanks. Tina? Oh, I'm sorry. Tina said she had to drop early. Valerie Grey?

Valerie Grey – New York eHealth Collaborative – ISP Task Force Member
Hi, Lauren. I agree with the earlier comments and I'm all set.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Okay. Last but not least, Victor Lee.

Kensaku Kawamoto – University of Utah – Co-Chair
Victor, you're muted if you're talking.

Steven Lane – Sutter Health – Co-Chair
I don't see him on the attendee list, so he might have dropped.

Kensaku Kawamoto – University of Utah – Co-Chair
He was on earlier.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
So, Steven, again, I have a list of those who we didn't hear from today, so perhaps we can circle back on the next call, but I will turn it over to you and Ken for next steps.

Steven Lane – Sutter Health – Co-Chair
That's wonderful. Thank you so much, Lauren. Go ahead, Ken.

Kensaku Kawamoto – University of Utah – Co-Chair
Steven, do you have any that you'd like to add as well?

Steven Lane – Sutter Health – Co-Chair
Thanks, Ken. As co-chairs, we have a different role. I just wanted to make sure that – Clem had raised the issue earlier about what data is available, and I think that you had a section where you were commenting on the role of USCDI with regard to use cases, as Terry raised, but I think getting Clem's comment in there is critical. And then, the only other thing I was going to say more generally is that we as your co-chairs will go through this and try to reorganize it, and we'll bring it back to the group at our next meeting and see if there are any residual comments if people had a chance to think more, and then orient us back to the use cases after we've done what we can to clarify the priorities themselves. Ken, I think you deserve a chance to chime in as well.

Kensaku Kawamoto – University of Utah – Co-Chair
Great. I'll add a few. I think under Privacy, it's really important that only minimally required data are shared, e.g. for FHIR scopes. That's kind of a technical discussion, but it's an important one and a relatively doable fix. And then, I'd just go into the notion that we need agreement on a publicly accessible set of detailed clinical models to achieve through semantic interoperability. I think anybody who's been in this space knows that we've got to define things at a much deeper level for some items, and I think we need to figure out how to do that, but that's it.

Steven Lane – Sutter Health – Co-Chair
Great. So, with regard to next steps, we have a slide up which lays out the timing of our next few task force meetings. The next one will be two weeks from today. Again, we have 90-minute meetings planned. The HIT advisory committee itself is going to be meeting the Wednesday after Labor Day, and again, all of these meeting dates and specifics are posted on the web for the public to see, as well as for all the task force members. Are there any other comments that task force members want to bring up? There are no hands raised at the moment, but if people have anything else they want to add, either about the content or the process… Andy, I see your hand is up.

Andrew Truscott – Accenture – ISP Task Force Member
Yes, hi. Just a quick one. I want to agree with what Ricky said. I think it would be very easy for us to lose sight, though, of the comment he made around a more infrastructural standardization, actually understanding what APIs, interfaces, or whatever are available from any given provider at any given moment. I think we could very quickly move on to more functional-type standards without actually giving sufficient attention to those more infrastructural components. I think we need to make sure that's covered.

We often talk about syntactical standards and semantic standards, and those are a couple of the dimensions of interoperability, but just make sure you don't forget provenance and context as well, and how that is truly exchanged to enable interoperability to take place. I think that's important. Finally, a previous commentator spoke on clinical decision support, and I think I heard them say we possess decisions that are made. Absolutely, but we should also make sure we possess the information

those decisions were made with, just so you've got those two facets in supporting that. That's it. Great call. I really enjoyed it.

Steven Lane – Sutter Health – Co-Chair
Great. And, David, maybe you can get the last quick comment in.

David McCallie – Cerner – ISP Task Force Member
Sure. The one thing that didn't come up that I had intended to mention but I don't think anybody said anything about was advancing the notion of how you do interactive care planning. We have care plans that are static documents to be exchanged today, but I don't think that's going to cut it for population management, so I'll just put it on the list that maybe we should put interactive care planning in the Infrastructure category.

Steven Lane – Sutter Health – Co-Chair
Thank you so much. David, your comment brings us to time. I want to thank everybody for their participation and their input. I'm really glad we gave everyone a chance to talk. Ken?

Kensaku Kawamoto – University of Utah – Co-Chair
Thanks so much for joining us in the peak of summer vacation. I appreciate it.

Steven Lane – Sutter Health – Co-Chair
We'll see everyone in two weeks.

Lauren Richie – Office of the National Coordinator – Designated Federal Officer
Thank you, everyone.