Interoperability Standards Priorities (ISP) Task Force

Transcript
August 14, 2018
Virtual Meeting

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning, everyone. And welcome to the ISP Task Force. We have a full agenda today, so we're going to get started starting with a roll call. Ken Kawamoto?

Ken Kawamoto – University of Utah – Co-Chair
Here.

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

Steven Lane – Sutter Health – Co-Chair
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Andy Truscott? Not yet. Anil Jain?

Anil Jain – IBM Watson Health – ISP Task Force Member
Here.

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

Arien Malec – Change Healthcare – ISP Task Force Member
I'm here.

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

Clem McDonald – National Library of Medicine – ISP Task Force Member
Here.

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

Kara
I'm calling on behalf of Cynthia Fisher. She's on a plane right now. This is Kara Grasso.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. David McCallie?

David McCallie – Cerner – ISP Task Force Member
Here.

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

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

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Les Lenert? Okay. Jack Po? Raj Ratwani? Ram Sriram?

Ram Sriram – NIST – ISP Task Force Member
Here. I'm here.

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

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

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

Designated Federal Officer
Sasha TerMaat?

Sasha TerMaat – EPIC – ISP Task Force Member
Good morning.

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

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

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

Cheryl Turney – Anthem – ISP Task Force Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Terry O'Malley?

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

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Tina Esposito? I believe she's going to be absent today. Valerie Grey? And Victor Lee? Okay. We'll circle back to the attendance later in the call. At this point, I will turn it over to Ken and Steven.

Steven Lane – Sutter Health – Co-Chair
Good morning, everyone. And thank you so much for joining us again this morning. It's great to have everybody. We did want to welcome one additional member to the task force, Cheryl Turney, from Anthem Blue Cross Blue Shield is a member of the Hi-Tech and was out of town, when we were first getting started. Subsequently, she made it back and expressed a strong desire to join us. Cheryl is the senior director of All Payer Claims Database Analytics and Data Policy and Administration at Anthem. And welcome, Cheryl.

Cheryl Turney – Anthem – ISP Task Force Member
Thank you very much.

Steven Lane – Sutter Health – Co-Chair

Ken, do you want to take us through the charge here?

Ken Kawamoto – University of Utah – Co-Chair

Sounds good. So, as we've reviewed before, what we're tasked with doing is making recommendations on prior uses of health IT and the associate standards implementation specifications. One note, the last time we met, we focused a little bit more on what I'd consider maybe the standards and needs there, maybe before we went to the priority uses of HIT. So, one thing we'd like to do today is to start thinking in terms of priority uses again. And we have some strawman that Steven will go through around that that we'd like to discuss. And associated with that is just the recommendations, in this area, and to publish a report. Can we go to the next slide? Okay. Let's see. So, again, we'd like to go into a discussion of priority uses.

Maybe before we get into that aspect though, Steve and I thought what we can do is recap what we discussed last week, maybe see if anybody had any other comments before we go into the priority uses discussion. So, perhaps we can do that. Let's see. Can we go to the next slide as well and see –

Steven Lane – Sutter Health – Co-Chair

Yeah, I think, Ken, you want to go ahead and share your screen and bring up the document we were working on together last time.

Ken Kawamoto – University of Utah – Co-Chair

Yes. So, I'm going to share my screen.

Steven Lane – Sutter Health – Co-Chair

And while Ken is doing that, again, our goal here, we know a number of people, last time, did not either weren't in attendance or didn't have a chance to comment or perhaps went home and did some more thinking. And so, we wanted to give people a chance to add any more to this discussion. We got a lot of this down very nicely. We did get an email response from Tamer Fakhouri who is unable to join us. And I thought that I would simply share that with the group as a kick off. Tamer said that – and recall that Tamer is from One Medical where they have built their own home grown EHR, and they're doing a lot of good work to integrate that with interoperability solutions. So, he said, "We would suggest prioritizing transitions of care use cases, including hospital admission and discharge and specialist referrals, as well as secure clinical messaging across health systems.

To support these uses, we're interested in how standards could simplify the task of reconciling external data with the EHR and allow for automated handling of external data. Another area of interest is in privacy and information security. For example, the ability to understand the security posture of health system partners and other entities in the healthcare ecosystem, so that we can be informed of potential risks related to data exchange. We are also interested in how standards could support providing patients

transparency and to where their data has been sent and, potentially, allow them to set permissions around how their data could be shared. So, we just wanted to share that with the group and capture that as best we could in Ken's document. Ken, how is that going with the sharing? I know it's a little tricky."

Ken Kawamoto – University of Utah – Co-Chair

Let's see. Firefox was having trouble. I've joined again as Ken Kawamoto 2. If you can promote that one to presenter, I think that should work better. Perfect. Okay.

Steven Lane – Sutter Health – Co-Chair

So, if anyone has any additional comments that they want to share, if you want to just use the hand raising feature, and then, we'll call you out.

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

Is there a document that has sort of the current best suggestions? I don't know what we're signing against.

Steven Lane – Sutter Health – Co-Chair

Yeah. So, Clem, thank you. We have posted the documents that we're going to be looking at today to the Google Share drive. That URL was sent to everyone. We can maybe, Sarah, if you want to pop the URL into the chat, so that people, again, have access to that. And we'll include it again with the notes. I saw a hand up, and then, it went down again. So, this is the document – there we go, it's back up again. So, this is the document that we worked on last time. So, since Ken is going to be real time editing with any comments or responses, I'm going to be managing the hand raising. So, Ed Juhn, do you want to go ahead?

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

Sure. Can you hear me?

Steven Lane – Sutter Health – Co-Chair

Yes.

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

Great. Just adding to what you had just spoken about with what Tamer had said, just adding to that, I think when we talk about transitions of care, I think it's important to look at where these transitions of care can occur. Hospital discharge is, obviously, a big one, given that it's associated with different HEDIS quality measures, but also, the ER discharge and the SNF discharge as well, as also areas of focus. I also think that another area to look into that ties to transition of care is medical reconciliation, especially this is where gaps are identified, gaps are closed. And various quality gaps in care can be addressed as well, such as missing vaccinations, beta blockers, aspirin.

Steven Lane – Sutter Health – Co-Chair

Just a question, Ed. This is Steven. When you say medical reconciliation, are you speaking

specifically to medications, and you included immunizations? Are you talking about reconciling other things like problems, allergies? You mentioned immunizations given in the patient setting. But, obviously, there are other lists, if you will, attached to a patient's electronic health record besides medications, which, sometimes, need to be reconciled or updated, at the time of a hospital discharge. Were you including that?

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

Yes. I think the broad scope, inclusive of medication reconciliation and what you had just mentioned.

Steven Lane – Sutter Health – Co-Chair

So, problems, procedures, those sorts of things?

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

Yes. Okay. Any other comments?

Steven Lane – Sutter Health – Co-Chair

Yeah, Clem, you have a hand up?

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

Yeah, the whole thing, the name of all of this is interoperability. And in the very beginning of all of our meetings, we had a list of things that maybe should be interoperated. And I don't know where to put things like we still don't have radiology reports or EKGs or any of these kind of base pieces of data that are used in clinical care. Nor is there a big header saying I guess quality patient care might be the answer there. So, what can we start to kind of get done with this simple, existing data shipping out to places that's needed to the patient and to the hospital and to the clinician.

Steven Lane – Sutter Health – Co-Chair

Yeah. I think you make a really good point, Clem. And part of that, I think, is acknowledgment, once again, that the work of this group really links up with the work of the USCDI Task Force and the whole USCDI effort, which is really getting at what it is, as you say, that we are interoperating. What are the data elements, data types, etc., that we need to be able to share? So, the good news is that we have Terry O'Malley who is one of the co-chairs of the USCDI Task Force here with us. And he actually had the next hand up. So, maybe I'll turn it to Terry and ask you to respond.

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

Okay, Steve, thanks. These are all great comments. Just to add a couple other into the mix. I guess one is do we want to look at functions, things that people have to do? And I think reconciliation is a great process. And it cuts across allergies, problems, medications. So, I think it's one of those fundamental processes. And I don't know if we're going to be tasked with helping to build the underlying standards for that process. But that aside, there are a couple of other processes that are essential building blocks that I think we might want to look at. One, again, is patient identification and how do we know who we're dealing with. And

then, the permitted uses beyond what TEFCA says, but the permissions that the individual gives for the use of his or her data, I would add those in. Thanks.

Steven Lane – Sutter Health – Co-Chair

Thanks, Terry. David McCallie?

David McCallie – Cerner – ISP Task Force Member

Yes. One of the things that struck me at the recent ONC Interoperability Forum that we had in Washington, some of us were at it last week was the number of times when we were discussing successes and failing in interoperability that it struck me that many of the failures were not so much about failures of the standard or the standard being missing, but rather failures of what I would call a business case or business processes that actually would support the use case. So, there were quite a few cases, medication reconciliation was one of them, where it struck me that the real issue was, in that case, for example, there's no one who really has a clear incentive and responsibility for performing the medication reconciliation. And it's not so much about standard as is it as about a business process.

So, I think that, as we go through these, maybe one thing we should think about, in addition to the interoperability standards needed, is what are the pre-conditions for there to be a business case, in the first place, for it to happen. Maybe that doesn't make sense, but it struck me, last week, that there are quite a few of the hot buttons here that are really not about standards but are about business cases.

Steven Lane – Sutter Health – Co-Chair

I think that's a really good point, David. And thank you for sharing that. And I think it speaks to the opportunities that we have in writing our report back to the HITAC and to ONC. I think we want to highlight those kinds of issues because, of course, while we can't create a business driver. CMS can, ONC, potentially, can. There are other levers within the federal process, as well as within the business community that, potentially, could be pulled. And I think it is really important to call that out. Arien?

Arien Malec – Change Healthcare – ISP Task Force Member

Thank you. So, first of all, I want to double down on David's comment. This has been, I think, the perennial lesson of healthcare interoperability that, in many cases, standards are dressed up with no place to go or limited place to go. One of the other big lessons, and I want to double down on Clem's comment, and, actually, I was surprised that David didn't double down on Clem's comment, is that, independent of the USCDI, I think we've underestimated, as a nation, the clinical and clinician need to receive simple, text based narratives that are clinical and summarized in nature, in transitions of care and in other data exchange. We have tended, in our work, to give data that's oriented towards machines to handle directly to the clinician, and that's led to the infamous, 45 page, rendered CDA.

So, I do think we should prioritize making sure that clinicians receive simple, human curated clinical narrative, as a core interoperability requirement.

Steven Lane – Sutter Health – Co-Chair

Thank you, Arien. That's great.

David McCallie – Cerner – ISP Task Force Member

I heartily endorse Arien's point. This is David.

Steven Lane – Sutter Health – Co-Chair

Thanks, David. Clem, your hand is still up. Did you have another comment, or is that from before?

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

Well, I did. I put it down and brought it up again. And I think that the point really isn't – I mean, the CDA, we all understand it. I'm not going to try to brag about it at all. But there's so much structured data sitting in computers that's clean and easy to read to send out, whether it's structured or text, whether an x-ray report is typically just text. There's spirometry that are typically structured. But they're what you see, what you've always seen, but they're not coming to us. And nobody has talked about it for 10 years, except maybe I've hollered about it. That's the key first step of interoperability. What's sitting there begging to be sent, and we don't send it? Well, we don't send it properly, so it gets to the other place.

Arien Malec – Change Healthcare – ISP Task Force Member

Yeah. So, then, my comment is slightly different from Clem's. And I'm just raising the clinical saliency and also interoperability, usability, and clinician satisfaction saliency of receiving simple, human curated text, particularly on transitions of care.

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

Yeah, I'm for that, too. But I want to get into one other thing about the medication reconciliation. We talk about it in sort of an abstract sense. But it's reconciling with that? Ideally, you'd have some really good set of things to compare with, and it would be very easy to get it done. And there are opportunities. In medicine, there's these large databases. Sure Scripts has one. There may be other ones. If those were provided to the office that would be trivial to reconcile what's in their files and what the patient says. And the same would apply maybe to immunizations because they're supposed to be all sent to public health. But no one is talking about delivering this out of a master set in which to make the comparison.

Steven Lane – Sutter Health – Co-Chair

Great comments, thank you. Ricky Bloomfield?

Ricky Bloomfield – Apple – ISP Task Force Member

Yeah, I just wanted to emphasize the point that Arien made around transmitting narrative data at transitions of care. And I think that the work that the Argonauts Project is currently doing around clinical notes would likely help to satisfy that. But what it doesn't satisfy is the clinical work flow to encourage providers to create those narratives because that can vary widely between health systems and EHR vendors. And if the clinical work flow incentivizes the provider to send a composite structured, machine readable document rather than the

narratives, then, that doesn't solve the root problem there. And so, we just need to think about how we make sure we incentivize the provider to actually create, manually, a concise summary that is useful because I've been on both sides of that, and it can be frustrating.

Steven Lane – Sutter Health – Co-Chair

Yeah. That's a really, really good point, Ricky. David McCallie?

David McCallie – Cerner – ISP Task Force Member

Yeah, just to agree with Ricky's point. I had sent you guys an email after our last meeting, and I'm not seeing it in here, but he was referring to a joint recommendation from a group that Argonaut hosted with Common Well and Care Quality members that were proposing some new templates or I guess some implementation guides around existing CDA templates that would address those narrative gaps. And I just want to say that work has been done. And now, the question is getting a priority on adoption of it from the vendor community, which I think kind of occurs best, when everybody feels like they need to do it, rather than one at a time. So, there is work that we could quickly prioritize that the hard work has already been done. I think that Ricky was referring to it.

It doesn't solve the broader problem of whether the text exists in the first place. But if it does exist, we can do a much better job of sharing it with a modest amount of work using existing structures.

Steven Lane – Sutter Health – Co-Chair

If I can chime in, this is Steven Lane. Just to be clear, I think the Argonaut work around sharing clinical notes and the care quality work being done with common while on the same topic, while I think closely related and both supported by some of the same people, are actually two separate work streams. But I couldn't agree more that I think one is about sending notes via fire. The other is about sending notes via CCDA. But I think you're absolutely right. We need to do that. And, Ricky, your point is well taken that you can only send a note that's actually been created. And if all people are doing is checking boxes and filling out flow sheets that doesn't create that patient story that I think we're all so attuned to. The other thing though that I think Arien was pointing out was a little different, which is the notion of ad hoc clinical messaging to support care coordination between providers.

Often times, if I'm a PCP, and someone else is a specialist, we'll share our notes with each other. But there's sometimes just a need to send a little message and say hey, I saw Mrs. Wong, and you need to watch out for X, Y, and Z. And it may not go in the clinical note but still warrant exchange using direct or other tools that I know Arien is quite familiar with. So, I just wanted to separate out those two.

Arien Malec – Change Healthcare – ISP Task Force Member

Thank you. And if only we'd worked on a standard to address that problem.

Steven Lane – Sutter Health – Co-Chair

Take your tongue out of your cheek, Arien.

David McCallie – Cerner – ISP Task Force Member

So, this is David. I'll pile on that. Also, because the other thing that came out of the meeting last week was the #kill the fax or eliminate the fax. I can't remember what the exact hash tag was. But I believe Irma made that a major commitment by 2020, we'd eliminate the fax. So, to do that, some of this work that we're discussing here has to be well understood. So, how do you eliminate the fax by using direct? Well, you've got to have clear understanding of how these things integrate into work flow and what you can do with an inbound or an outbound message. Some of that is just vendor specific work to be done. But I think, if you put expectations that your vendor needs to be able to do this, that's going to be part of making it work, instead of just having technology that nobody uses.

Steven Lane – Sutter Health – Co-Chair

I wanted to ask a question because one other methodology, which I know is used, especially in the hospital setting but I think also in the ambulatory and potentially homecare world, is the notion of secure text messaging. And no one has mentioned that. We talk about sharing notes. We talk about sharing messages in the sense of secure medical email. But is anybody on the task force particularly excited about the need for standards around secured real time text messaging?

Arien Malec – Change Healthcare – ISP Task Force Member

I will point out that, in the direct project, one of the early implementations was using an open messaging protocol and looking at securing it, as a universal transport method. And we thought, at the time, that it was too early. But it's pretty clearly a salient need. My mantra is the few things that are getting done ad hoc in practice are probably good opportunities for standardization. I'd also note, from a HIPAA perspective, ideally, that stuff should be part of the patient designated record set, and it should be available, ultimately, for access. So, there's maybe some concern, if people are texting back and forth relative to clinical care, and that stuff is not actually landing in the chart.

Jack Po – Google – ISP Task Force Member

I would say that secure text messaging, along with actually multimedia that is frequently included in the text messaging, is something that's very important. Speaking to the fax point that was just mentioned, sort of the new incentives for tele medicine, I would say that it would be useful for us to get ahead of that and start to make sure that a lot of these silos don't start getting created in tele medicine.

Steven Lane – Sutter Health – Co-Chair

And I'm sorry, who is speaking?

Jack Po – Google – ISP Task Force Member

Sorry, this is Jack.

Steven Lane – Sutter Health – Co-Chair

Jack, I'm glad you made it.

Jack Po – Google – ISP Task Force Member
Thanks.

Steven Lane – Sutter Health – Co-Chair
Great, all right. So, I see, David, your hand is up again.

David McCallie – Cerner – ISP Task Force Member
Just a comment on the text messaging. I totally endorse that that's an issue. And it's really proprietary silos today, and it's frustrating. So, I don't know if there's a will in the industry to bridge across those silos. But we've got them, and I think that's something we should at least discuss, how to bridge the secured texting networks.

Ken Kawamoto – University of Utah – Co-Chair
Yeah, I had a similar thought in that the secured texting, the predominant use case is intra health system rather than inter health system. And while there certainly is a need for inter health system, the work loads aren't yet as robust to handle that scenario. So, I'm afraid, if we really went down that path to solve the problem, it would be all dressed up with nowhere to go type scenario where I think that the business process first needs to be aligned. I agree there's a need there, but I'm worried that we're not quite ready for that. And I don't know the exact steps that we should take to get there. But it's an incredibly complicated issue.

Steven Lane – Sutter Health – Co-Chair
Hey, guys, let's keep working with the hand raising, okay, as best as we can? Sorry, David. I didn't mean to step on your toes there. Why don't you go ahead?

David McCallie – Cerner – ISP Task Force Member
I wasn't following the rules. I apologize. But a one sentence reply, which it does come up with interfaces between vendors' proprietary text messaging and a third party proprietary text messaging that might be in use in the hospitals the vendor is in. So, we wrestle with this problem a lot because we get two choices for text messaging, and they're not bridgeable, at the moment. So, within a single facility, the issue is real. It comes up.

Steven Lane – Sutter Health – Co-Chair
Yeah, it's a good point. In addition to welcoming Jack Po, I think we got Raj Ratwani joining us. Is there anybody else who joined after we did the roll call?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Steve, this is Lauren. I believe Les Lenert joined as well.

Steven Lane – Sutter Health – Co-Chair
Great. Welcome, Les. All right. The hands are down, which I think is perfect timing, as we come to the half hour because what we wanted to do was pivot a little here from this kind of

open ended collection of input to start to try to focus ourselves on some specific uses, based on all of the comments that we've received. And I don't know, Ken, can you give up the screen sharing, and I'll try to grab it?

Ken Kawamoto – University of Utah – Co-Chair

Yeah. It's available.

Steven Lane – Sutter Health – Co-Chair

I see it now. It's a little tricky.

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

Steven, this is Terry O'Malley. Just a comment while you're swapping. And that is what sort of process are we thinking about for establishing prioritization and priorities and whether, in parallel to the USCDI, we want to think of a process for interoperability standards priorities that helps us identify emerging priorities and get a process in place for addressing them, closing the gaps, rather than to make sense of what we're doing is kind of a very smart committee thinking really hard about what the priorities are now. But we may want to think about a process that allows us to identify emerging priorities.

Ken Kawamoto – University of Utah – Co-Chair

Clem has his hands up. Clem?

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

Yeah. Well, he opened up the door with the USCDI. I never had the impression we solved what data should be shipped in USCDI. And I thought this was going to be dealing with it. And I'm still coming back through we've got a very meager flow in real healthcare right now to the clinician's office.

Ken Kawamoto – University of Utah – Co-Chair

Maybe, Clem, if I could comment on that. I think one approach to do this is where we're pivoting to, where we're talking about what are the priority uses. And I, specifically, am passionate about the notion of disease management and health maintenance and provision of evidence based medicine for the most common conditions that afflict us. And I think, if we focus sort of clinically, it becomes obvious, oh, if we want to care for hypertension, we're missing this data. If we want to care for diabetes, we're missing this data. Does that make sense? Cardiovascular disease, we need an EKG. Where are the EKG or echo results?

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

That's one way to do it, but there's this stuff sitting electronic for 20 years in someone else's computer, and we're not getting it. And radiology reports are the big one I rage about all of the time. Why be selective, when it's all going to come from the same site? And it's getting them to send it is the issue, not getting the clinical systems to receive it.

Steven Lane – Sutter Health – Co-Chair
Let's go ahead and pivot a little bit. I brought up another document called Priority Uses of HIT. Can everybody see that?

Ken Kawamoto – University of Utah – Co-Chair
It's kind of small on my screen. Is there a way to make it bigger?

Steven Lane – Sutter Health – Co-Chair
I don't know if I have any control over that.

Clem McDonald – National Library of Medicine – ISP Task Force Member
It's pretty much invisible.

Steven Lane – Sutter Health – Co-Chair
Okay. Let me try a different approach. Let me try sharing it as a –

[Crosstalk]

Ken Kawamoto – University of Utah – Co-Chair
You can zoom in on your screen.

David McCallie – Cerner – ISP Task Force Member
Yeah. Zoom in on your desktop, and I think it will pick that up.

Steven Lane – Sutter Health – Co-Chair
Let me share it as the Word document instead and see if that works better. How's that?

Ken Kawamoto – University of Utah – Co-Chair
It's still similar. If you can zoom it, I think it would help.

[Crosstalk]

Steven Lane – Sutter Health – Co-Chair
Is that any better? Okay. Excellent. Great. Okay. So, this is a document that we put together as a little bit of a digestion of the discussions that we've been having. And we wanted to kind of walk through it. This is also on the site. For purposes of display, I'm not sharing the document on the site in real time, but I'll update that one with any changes that we make here. But what we thought we would try to do, in terms of the tactics that we would use to tackle this work, would be to try to identify a small number of uses or domains of uses to focus on in depth and, potentially, break the task force into a small number of working groups that would be able to deep dive. And we've been talking with the team at the ONC to see whether they would be able to support that logistically.

I think it's still a little bit of an open question. But we wanted to discuss this as an approach with all of you and see if this makes sense. What we were thinking was that it would be worthwhile, and we discussed this a bit earlier, that we want to take full advantage of all of your time and experience and intelligence and to try to make the work of this task force really meaningful for the country. So, we wanted to propose, and these are all open to discussion, that we would focus on uses that are new or emerging. That haven't had a lot of focus in the past where the technology or the work flows or whatnot haven't been there, rather than necessarily trying to re-hash work that's been done. Though, I think as Clem points out, there's work that perhaps could have been done that hasn't been done thoroughly. But, again, it's kind of an initial thought that we would focus on new areas, new uses, and those that haven't received adequate attention.

Also, since we're all about standards and prioritizing standards and then, supporting the development and evolution of standards, we think it might be useful to look at uses that lack either established or well adopted standards. And I think we had some comments in that area that standards may exist, but we don't have the work flows, we don't have the business cases, etc. We want to look, potentially, at uses that would benefit from the engagement and input of new stakeholders. Again, we have some relatively new stakeholders or old stakeholders representing new domains on this task force. And I think there's a great opportunity for us to think about stakeholder groups that have not been well represented in the standards development process. And, again, look for opportunities that will have a real impact on our industry and on society.

So, maybe I'll just pause there and see if there are any specific comments about those as kind of priorities to shape our focus.

Ken Kawamoto – University of Utah – Co-Chair

David?

David McCallie – Cerner – ISP Task Force Member

I like this. My only concern is that we not be distracted by the shiny new thing and never finish the boring, old thing. So, in discussions that have come up today already, we've had a bunch of things that are kind of completing or finishing or fine tuning existing stuff. And I would hate to see us ignore that. So, maybe it just goes into a category that we could call work underway that we endorse to be finished or something while we talk about new things. Does that make sense? Don't imply that we think the old things are finished, necessarily, if they're not, even if we go focus on something new.

Ken Kawamoto – University of Utah – Co-Chair

Next is Clem.

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

Am I up? Well, I'm going to reinforce and re-assert, so I thought sort of one of the end goals was to see what would be regulated or at least encouraged by federal agencies. And as they

mentioned maybe 100 times, there's no assertion about anything about radiology results, except a little bit in the CDA, which has its own problems. And why couldn't they just send them back to the clinicians or the place – even hospitals go to outside places with radiology reports. Even the lab is not done yet. You don't get labs coming in a standard way for most places still. And these are relatively easier than trying to construct new kind of processes and get physicians to do more stuff. So, I don't know, I've just got to harp on this. I'm going to have to apologize.

Steven Lane – Sutter Health – Co-Chair

That's okay, Clem. We hear you.

Ken Kawamoto – University of Utah – Co-Chair

Maybe one way to capture that would be to say the biggest bang for our buck or achievable yet impactful is I think the notion. Terry is next.

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

Yeah, thanks. And let me reinforce Clem's point. In the original USCDI list that we all looked at and said they're missing all sorts of really important things from emerging groups, but we might want to focus on the work that needs to be done to make sure that's a priority. So, everything Clem has been advocating for throughout USCDI I think makes a lot of sense. And for assets in parallel, let's clean up the old stuff. But the process that you've outlined here to sort of look at the new stuff I think makes a lot of sense. But I would do both of those just because there's so much value that hasn't been tapped yet that we just really need to get the data out and moving. So, Clem, I agree with you.

Steven Lane – Sutter Health – Co-Chair

So, let me go on with sort of our proposed tactics here. So, again, we want to identify what would be really our high priority domains or uses that we want to focus on. We want to select a small number – this is my proposal. We would want to select a small number of these to really drill down on. So, we're not sort of trying to cover the waterfront, but we're actually trying to add value in some specific priority domains. And one way to do that would be to break into working groups. We have a 22 member task force. If we put four to give people on a working group that would give us four to give groups. If we made them a little bit bigger, we could maybe narrow it down to a smaller number. But the idea of this is a large group. We've got a lot of great ideas.

And some people are more vocal than others. But we really want to leverage all of your input and expertise. So, this is a proposal that's on the table to break into working groups that would work in parallel and do deeper dives. We want to think about what each group would be responsible for. And it might be a little bit different, based on the domain that they're looking at. And then, what we're proposing, and, again, we're waiting to hear from ONC whether they'll be able to support this, would be having these working groups meet kind of in parallel at the same time as these meetings are already scheduled. They'll, basically, break us apart into maybe it's going to end up being three or four different groups each with an ONC staff. This is tricky because those groups would be large enough that they would need to be in the public, so they would need a lot of administrative support.

So, again, we're still finding out whether we could get that. And then, those groups could take deeper dives. They could invite subject matter experts. They could really look into areas of interest. And then, each of them would have somebody kind of helping to lead and organize the group. I think Ken and I would each offer to take one, and we'd probably want to identify a couple of other task force members to kind of organize those groups. And then, we would intermittently have full task force meetings where the groups could kind of report back, this is what we're thinking. This is where we're going, and we can all kind of check and balance along the way. So, I'll pause there and just get people's feedback about this idea of trying to narrow ourselves down to some high priority areas, and then, breaking into smaller groups to focus on them.

Ken Kawamoto – University of Utah – Co-Chair
No hands up yet.

Steven Lane – Sutter Health – Co-Chair
All right. We'll take silence as agreement, unless we're misguided in that.

Ken Kawamoto – University of Utah – Co-Chair
Les has his hand up.

David McCallie – Cerner – ISP Task Force Member
This is David. I stepped away from the computer, so I can't raise my hand.

Ken Kawamoto – University of Utah – Co-Chair
Okay. David and then, Les.

David McCallie – Cerner – ISP Task Force Member
I've been on task forces that did this kind of thing, in the past. And I don't think there's a requirement that the sub groups be public meetings, as I recall. They have to report out, obviously, in our public overall group. But it might be possible to simplify the burden on ONC, if they're not actually required to every meeting be public. But I may be misremembering. But I think we've had task forces that did their work offline and then, reported out in public.

Steven Lane – Sutter Health – Co-Chair
Our understanding, David, in discussions with Steve Posnack and Lauren and others is that it has to do with kind of the size of the group and what it is that they're up to. And a couple of people can meet on the phone, maybe even three, and have a "offline" discussion. But what we've been told is, if it gets larger than that, and significant deliberation is going on, that would require them to be public. But I think, again, they're thinking that through with us presently. I don't know, Lauren, others, if you want to comment.

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

Sure, this is Lauren. I would agree. I would also just remind that, if we are bringing in outside things or experts in a panel style hearing that would also warrant having that in the public forum, so that others can see what the experts are bringing to the group. And then, just as an additional side thought, we can also think about perhaps staggering the groups or identifying if one should start now versus later. Or perhaps maybe kind of start one now and see how that goes, and revisit a little later on, since we do have a little bit of time. But, generally, that's the course that we prefer to take.

David McCallie – Cerner – ISP Task Force Member

That makes sense because my memory was of much smaller groups. So, that's what I was remember, just two and three people doing it. So, big groups, you need to be public.

Ken Kawamoto – University of Utah – Co-Chair

Les?

Leslie Lenert – Medical University of South Carolina – ISP Task Force Member

Yeah, my comment was that the logistics of this are pretty difficult. And ensuring that the groups don't overlap and don't come up with contradictory proposals is a substantial effort, in addition to just making sure that these meetings were public. So, perhaps, somewhat, I think it would make a lot of quick progress that would then need to be integrated tightly to move forward.

Steven Lane – Sutter Health – Co-Chair

Okay. That's all really helpful, and we will consider the feedback, as we put together our strategy.

Ken Kawamoto – University of Utah – Co-Chair

David has a follow up comment. Sorry, David?

David McCallie – Cerner – ISP Task Force Member

Yeah. I think Les raises a really interesting point. We've got a long enough runway for the overall group. I think we're booked out for almost a year. Maybe we just sequence the focus areas and say, for the next three meetings, we'll deal with this specific set of topics, so that we can all participate to the degree that we're able and want to. And maybe we have enough meeting time is what I'm getting at.

Steven Lane – Sutter Health – Co-Chair

Good point. All right. So, whether we end up running these in parallel or in sequence remains an open question. But my thought was that, as we focused in on these domains, that we would want to identify the existing standards and implementation specs, as we've been asked to do that would be needed to support the specific use cases or work flows, as well as any standards that may be lacking or incompletely implemented, which I think is what we were talking about earlier, including, to Clem's point, specific data elements that would be required in the USCDI to support the exchange of information needed to meet the priorities. So, I think this is where that rubber starts to meet the road and where, again, I think it's

important to acknowledge that this work runs in parallel with and supports the work of USCDI.

And then, the thought was that the smaller groups or perhaps our segments that we would bring it back together, I think to Les's point, wanting to avoid any conflicts or inappropriate overlaps that came up. So, thoughts on those ideas?

Clem McDonald – National Library of Medicine – ISP Task Force Member
I've got my hand up, but you didn't give me permission yet.

Ken Kawamoto – University of Utah – Co-Chair
Go ahead.

Clem McDonald – National Library of Medicine – ISP Task Force Member
The USCDI never did – they were developing rules for picking. They never did pick that committee. So, we're still stuck with lots of available data that's ripe for transmission that the rules don't push it hard enough to get it transmitted.

Ken Kawamoto – University of Utah – Co-Chair
I think though, Clem, what we're saying is, through this work, why don't we leverage that process and push for imaging reports and labs aren't being exchanged, etc., right?

Clem McDonald – National Library of Medicine – ISP Task Force Member
That's what I'm begging for, yeah.

Ken Kawamoto – University of Utah – Co-Chair
I think we're answering it.

Steven Lane – Sutter Health – Co-Chair
Okay. So, with that, any other comments? Great. So, with that, I'd like to propose, if you will, a slate. It's sort of a long one, of priority use I'm calling them domains for us to consider. And then, we can sort of talk about these a little bit. But I just want to throw these out there. These are based on discussions that Ken and I had and the feedback that we've received from you. And we'll see if we're kind of lumping and splitting these appropriately, as areas for our focus. And we put out six of these. Below this, there's a long list of other uses that we've discussed and some that we haven't focused in too much on. And we can flush this list out, based on the feedback today. But we felt that we could lump some of these together for focus. And I want to just kind of – I'm going to go through a bunch of them and then, open it up for discussion, if that's okay.

So, the first one, which, again, wasn't so much a use as it was kind of a data domain, which is the social determinants of health. I know we've all talked about them a lot. It would certainly be possible to focus on individual social determinants or the data class as a whole. I think

there have been requests, and some of these notes really came out of the discussions last week in DC, so people who were there will recognize some of these ideas. But the question of whether to provide a general structure and a place for social determinants data in health IT systems or to drill down more deeply, focusing on the value, as I think Clem, it's a point that you've made very nicely. What is the value of additional data collection? Who has to bear the burden of that data collection? And then, who derives the value from having the data and making it interoperable?

Looking at evidence about how this data can be put to use, again, and the value to patients and society. And as we thought about this, obviously, social history is something that clinicians collect routinely in different ways. Different systems support different ways of collecting that. I don't think there's a lot of standards around them. And certainly, social history today often involves substance use, other kinds of sexual history. But, of course, nutrition, housing is becoming much more prevalent, as important data elements. And then, the whole issue of how to integrate social services, how to know about social service availability, eligibility, usage, how to make referrals back and forth to social services. All of these, potentially, could fall into this domain that I've just labeled social determinants of health.

And I'm just going to go ahead and go through these knowing that there's going to be a lot of comments. Another one that Ken just mentioned, the evidence based medicine for common chronic conditions, Ken suggested looking at the top 10. But, obviously, diabetes, heart failure, COPD, chronic kidney disease would be in there. Looking at standards for data collection, the work flows associated with this, and how to interoperate really looking at assuring that we bring decision support. This is one thing that I left out here. To support best practices, and then, looking at what is the highest value data to be able to share and interoperate. And, again, this goes back to Clem's comment.

We've got lab values. We've got other kinds of data that could be particularly valuable to support evidence based medicine and looking at the value of making key data items interoperable. The next general domain that we sort of lumped together was around medications and pharmacy data. I think I've mentioned here the challenge. I certainly mentioned it in DC last week, the challenge of medication reconciliation and the value of having discrete SIGS, in order to be able to put machines to work on duplication and reconciliation. There's, obviously, challenges around fulfillment data, adherence data. I don't think there are any standards around that. And, obviously, opioids are a key use case or a key area within medications that's getting a lot of focus. And I think Ken made a really good point that it would not be a bad idea, if we put some of our energy into work that would help support the development and promulgation of solutions to help with the opioid crisis.

Of course, having national standards for interacting with PDMPs would be valuable and something that is clearly lacking. Shared pain management care plans would apply not only to opiates but to other medication classes as well. And then, there's a lot of work going on with opioids around shared decision making. So, those are all things that potentially could fall into a medication pharmacy focus I think really with Med Rec being a key piece of that. Close up referrals was another focus last week. And I think really, while it was very exciting to see the progress that's being made with the 360X work, including a number of the vendors who

are on the call here, there's clearly a lot of opportunity. And I think we heard some comments earlier this morning and from Tamer. Transitions of care referrals is clearly a part of that. There are big, open questions about what data is needed to send to consultants.

We've talked, in other venues, about getting specialty societies involved in that. But, again, a real opportunity for standardization. Standards related to communications, again, overlaps with what we were discussing earlier. But there are really no standards for provisioning or maintaining direct addresses, whether it's at the provider department, location, or organization level. And message context is something that, while there are standards out there, they haven't been well implemented. And I think that those are going to be very important to support efficient work flows for messaging. So, again, potential domain for focus. Orders and results, another big area. Ken has pointed out the challenge of not having standardized orderables across EHRs and health IT systems was mentioned earlier by Clem.

The discrete lab data exchange, whether we could identify high priority labs and result components, whether we could get all systems that are generating and utilizing lab results to consistently apply link mapping. That would be a huge step forward for our ability to share lab results efficiently. And then, of course, here again, there's a big, gaping area around genomics data. What are the standards there? A lot of work has been done, but I don't think they're well established. And then, I think there's a very specific use case around orders and results going between systems. Today, we build innumerable point to point interfaces to support orders and results. Presumably, we could develop standards that would allow those to flow much more efficiently. And then, the last area that I think a number of you commented on, I think David, in particular, at our last meeting, was around what was referred to as cost transparency.

But I think we lack standards for claims data, how to move that between entities, how to integrate that data into EHR systems and put it to work to support decision support, quality reporting, optimization, etc. Within this bucket could fall the whole issue of transparency of cost related tests, medications, patient co-pay responsibilities, and then, the area of prior authorization. So, we did a lot of lumping here, putting together these six potential domains. And I wanted to sort of throw out the idea that perhaps we, as a group, we can massage these, we can throw some things in or take some things out. But the idea of asking us to vote each individually to identify or to prioritize these areas, or if we want to bring some of these others up, patient matching came up, a number of other areas are down here that we've discussed.

But trying to get ourselves to a point where we have a prioritized list whether we're going to work on some of these in parallel or work on them all together as a task force. So, I will stop talking and let Ken run the discussion and ask for feedback on this list.

Ken Kawamoto – University of Utah – Co-Chair

Anil has his hand up.

Anil Jain – IBM Watson Health – ISP Task Force Member

Yeah. Thank you, guys. This is a very interesting list of six. I just would like to offer two

additional ones, and maybe they're in the other pile. You went through it very quickly. I didn't see it. But as a complement to evidence based medicine, I think the priority for interoperability and the true potential promise for having all of this data would be to complement evidence based medicine with personalized medicine. I saw genomics on there. I saw social determinants of health. But how do we actually fold it into a broad based way of thinking about interoperability as a focus for accelerating personalized medicine as a complement to evidence based medicine? The second one I didn't see on there. I saw the optimization of orders and sort of closed loop referrals.

But I think the pain point that I hear about when I go around is the challenge with prior authorization. And if we start to think about how some of these capabilities actually create business cases, prior authorization that could help providers, help hospitals, help fee payers, and collect the evidence we need in order to really make sure that these therapies and treatments are actually making a difference could be an interesting priority for the group.

Ken Kawamoto – University of Utah – Co-Chair

David has his hand up next, and then, after David, Clem.

David McCallie – Cerner – ISP Task Force Member

Yeah, it's David. It's a good list. I think that before we do too much voting on prioritization, we ought to surface anything we know about existing work in the area that may already be underway, with hopes that maybe we don't need to duplicate it. And, in particular, I'm thinking of the cost transparency claims, prior authorization space, with what the Davinci group is doing. They're aggressively working on prior authorizations. They're also working on medication reconciliation, although I'm not sure that their view is as broad as the one you have listed here. But it would be a shame to try to replicate or duplicate work that's already underway.

We may want to endorse it and say it's important but maybe divide and conquer a little bit. I'm guessing there may be other activities in some of these other spaces. I just don't know as well, off the top of my head.

Steven Lane – Sutter Health – Co-Chair

And, again, I think that would be, as we drill down on these, either as an entire task force or as smaller groups, that would be the way to start would be to say what is going on. Again, what standards exist today, whether they have or have not been broadly implemented, etc.

Ken Kawamoto – University of Utah – Co-Chair

Clem?

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

Yeah. Just to reinforce the last two comments, so there are some things then. So, there is a specification for ordering an HO7B2, which was not adopted by ONC in the last round. And I think there's activities in the HO7 attachment group and with X12 regarding some of the prior authorization stuff. So, I reinforce what David said about let's try to collect some of

these documents and share them or the information that we do have.

Ken Kawamoto – University of Utah – Co-Chair

I don't see any other hands up. But I'll make a comment. So, as one additional comment on I think it was Item 1 or 2, I think it was 2, the evidence based medicine for chronic conditions and their health maintenance, I think the nice thing here is that it becomes very concrete and very immediately useful. So, for example, we may say we want to share information on this kind of domain. But, for example, in our institution, we have 4,000 labs. I think it's harder to say well, let's make sure all labs are always mapped properly to the link than to say well, across these important use cases, here's the 100 that we need to share, and let's focus on those. And I think the impact could be fairly large.

So, if you include things like lung cancer screening for people who meet US preventative services task force criteria for lung cancer, we already have well adopted, Argonaut profiles for smoking, but it doesn't include past year history. And a lot of systems do collect that information. Even if we could just use that, the estimate is maybe we can even save 10,000 to 15,000 lives a year. So, I think, relatively small things we can do for data that's already collected, if we just say let's look at the actual diseases that we're dying from, we could, actually, I think, have a pretty large impact and be very feasible. I see Clem has his hand up. Clem? Clem, you're muted.

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

I support everything you said. In fact, I'd like to work on this task group, if it would be created as one. But what you're assuming is the labs won't use proper messaging. And I think we ought to encourage that they do, so you don't have to map. That's the problem. We don't get the good stuff from the labs.

Ken Kawamoto – University of Utah – Co-Chair

Yes, agreed. David?

David McCallie – Cerner – ISP Task Force Member

Yeah. I have a gap here. It's an infrastructural gap that maybe it just infiltrates all of these. But I wonder if it's worth calling out. And it's really to kind of push on Clem's point that there isn't a standard way to distribute documents and results in a pub sub kind of fashion. I think individual institutions will set up, with their vendors, custom ways to do that probably to varying degrees of success. And we also have national query based approaches that are gaining traction and TEFCA would reinforce. But I don't know that there's an infrastructural approach to pub sub, so that you'd have some knowledge of this result should be distributed to these providers under these circumstances in a kind of background reliable way. And maybe that's just a local problem, but it probably merits some discussion.

Ken Kawamoto – University of Utah – Co-Chair

Next is Arien.

Arien Malec – Change Healthcare – ISP Task Force Member

Yeah. So, David and I did some work a while back looking at some of the underlying generals that are required. So, as an example, we hypothesized that, if you only made structured data available via Arrest API, with some security around it, it would open up an ecosystem on the app and patient site. So, it would be interesting maybe as a different way of slicing this to look at how best we can use the primitives that are already in practice. Fire based APIs, consolidated CDA, the variety of IHE document exchange standards and look at small changes to those that open up the surface area maximally. So, it's a different I want to almost say an orthogonal way of looking at these problems. The risk in enumerating a bunch of specified use cases is that we then think we need to go have a standard implementation for each of those use cases.

With regard to document interchange, it would also be interesting to look at what's out there and in practice. So, for example, secure exchange, in the same way that there's secure exchange of ORU and ORM messaging via sometimes for proprietary transport channels, but fairly well standardized at the API side, there's the same thing for MDM formatted reports. And a fair body of practice is sending MDM formatted reports via sometimes proprietary secure exchange. And then, I guess the last point, and I know that we're looking at priority use cases, and maybe this is a sign of my getting gold and cynical, but to David's point, with regard to the priority for interoperability, finishing what we started is at least as important, if not far more important, as establishing the priority use cases.

And maybe the final point, with regard to priority use cases, is that I think, with regard to achieving ACO, there are specific point problems as well as infrastructure problems, in assembly data that's required to compute clinical quality measures. Some of the specific point problems are lack of information, fidelity for clinical measures that require, for example, risk assessments or other kind of structured interventions. And some of the infrastructure problems should be addressed by things like flat fire and the authorization that's required and some of the work that Davinci is doing and the like. But I think we should, from an ONC priority perspective, we should make recommendations in areas that are important for national priorities that aren't universally and scalably getting done. That's it. Thank you.

Ken Kawamoto – University of Utah – Co-Chair

Les?

Leslie Lenert – Medical University of South Carolina – ISP Task Force Member

Yeah. I think that you've got a few topics on here that I think everybody would want to come to the groups on. It seems like we have – perhaps that's the first thing you've got to decide is which of these are so important that the whole committee has to debate these rather than doing them in a small group function.

Steven Lane – Sutter Health – Co-Chair

That's a really good point, Les. And, again, I think what we were hoping to do was, first, sort of settle on the slate that we would then ask people to vote on. And, again, we're just proposing this as a tactic here. And I've heard generally positive comments, I think, about sort of the top six, the way we floated these to the top. I'm not quite sure where to put

personalized medicine in here. I think it's certainly something that we're all aware of and sensitive to is the need to focus on patient data, patient access to data, leveraging data for the needs of the individual patient. So, I don't think we're going to forget that. Clem, we highlighted image exchange here. I think it, potentially, plays a role in some of the other domains that we discussed. But what we wanted to propose was –

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

Just to clarify though, it's not image exchange I'm pushing for, it's the report of the diagnostic study. It would be okay, too, but that's another –

Steven Lane – Sutter Health – Co-Chair

Whole other world, right. I appreciate that.

Ken Kawamoto – University of Utah – Co-Chair

Terry has his hand up.

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

Hi, thanks. Just a couple of comments. This list is apples and oranges, as Clem would say. I think we've got some like the first social determinants. It's really sort of a vocabulary semantics issue because we haven't even got the vocabulary. And then, some of them are more broad IT functions like document exchange and query, permitted use, unique identification. I'm wondering whether we might want to break these into two groups. And one would be what are the underlying functions that have to be in place that would help with the exchange of all of this information. And those are sort of the query document exchange ID. And what are areas that are emerging where we don't even have the semantic standards in place like social determinants and perhaps evidence based medicine?

Ken Kawamoto – University of Utah – Co-Chair

I wonder if that's along the lines of let's not step on each other's toes kind of notion of, if there's common functional elements that arise, as we're talking about these, that those are identified. And then, they're worked on, in a single thread, if that makes sense. I guess there was another comment earlier about let's not get so use case driven that we create a standard for exchanging medication fill data for hypertension. That would be really silly. So, maybe we're always looking for are there places where getting broader doesn't necessarily incur that much more cost. And we should generalize what we're trying to achieve.

Steven Lane – Sutter Health – Co-Chair

Also, Terry, I think, our charge on the task force is to focus on priority uses of health data. And I think that, as we do that, we will inevitably need to talk about both functions and the data needed. So, in my mind, it makes sense to kind of focus in on a domain and then, tease it apart and see what's needed there and then, make recommendations based on that, as opposed to saying you guys go look at functions, and you guys go look at the data that's needed and kind of artificially separating those. But that's just how I think.

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

No, I hear you. That makes sense.

Ken Kawamoto – University of Utah – Co-Chair

I think there's nothing more challenging than working on something without a really concrete use case in mind, maybe just because – I don't know. I just find that hard. I think it's always helpful when, even though your point is not just to solve this particular use case that you are use case driven or priority use driven because then, it really grounds what you're talking about. And especially when you have to make tradeoffs, it's much easier to say is it worth it for us to try to achieve this, given these costs, when it's less of a vacuum, and using this data and using these processes, this is what we would be able to achieve.

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

Here, here.

Steven Lane – Sutter Health – Co-Chair

So, I'm sensitive to the time. And I know we need to transition to bring in the public fairly soon. What I'd like to propose is that we'll figure out, with our friends from the ONC, how to create a simple ballot of these. And we'll just stick with these six. And I think asking each member of the task force to rank order their top three, let's just say. And we'll figure out a way to collect that information between now and the – well, we can either do that between meetings, or we could wait and do it at the next meeting. Personally, I want to get moving on this. So, I'd like to see if anyone objects to the idea of us sending out a ballot between meetings asking you to vote. And then, we will assemble a prioritized ranking of these that we can then discuss at the next meeting.

And by then, we should know from the ONC whether we can work on more than one of these at a time in parallel or whether we should just work collectively as a broad task force and start in on the top priority. What do people think of that approach?

Ken Kawamoto – University of Utah – Co-Chair

One relevant point I think we discussed was, if it's a priority, and we can get done with one of them, we can move on to more. It's not like we have to spend a year working on it. Anyway, Clem, you have a comment. Clem, you're muted. Clem, if you're talking, you're muted.

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

I am. I'm sorry. A given category, could we respond as to say some things we could drop off of because there's a mix match of things, in some of these categories, when we do our vote.

Steven Lane – Sutter Health – Co-Chair

Yeah. They're definitely lumped together, Clem. And I think, again, we were trying to kind of capture the domains of interest and see where this group is most interested in focusing our efforts initially. Once we get in, we can totally pull things in, toss things out. These are not meant to be set in stone. I'm a lumper. And these were meant to kind of lump things together into broad areas where I think we could do meaningful work. But it's only once we

get into them that the specifics would be sorted out.

Ken Kawamoto – University of Utah – Co-Chair
No other comments, hands raised.

Steven Lane – Sutter Health – Co-Chair
Fabulous. So, Lauren or Farrah, do you want to –

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yeah. I think this is a good point to go ahead and break for public comment. So, just as a reminder, if you have a public comment, please keep that to three minutes. And let's just do another quick check. Do we have Andy Truscott on the line? Okay. Operator, can you please open the line for public comments?

Operator
Lines are open.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And do we have any comments in the cue, at this time? I'm sorry. Can you confirm if we have any comments in the cue, at this time?

Operator
No comments, at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. I will turn it over to Ken and Steve.

Ken Kawamoto – University of Utah – Co-Chair
Steven, should we spend the time then, further discussing the potential priorities?

Steven Lane – Sutter Health – Co-Chair
Sure. Let's do that. Well, so, we collected a lot of comments and feedback. How do you want to approach that, Ken? What's your thought?

Ken Kawamoto – University of Utah – Co-Chair
I guess one approach right now might be just to get any folks thoughts on if we're missing any that need to make it into a list of potential ones to put in the vote. And I'd say sort of the vote with your feet kind of one. Which are the ones you'd personally be willing to spend a lot

of effort on to help move forward or otherwise just think it's really important? And then, maybe any other comments on it. Because we only meet every two weeks, I think we should use the time that we have. Any thoughts? Any that we're missing or any thoughts on these existing ones as priorities for you?

Steven Lane – Sutter Health – Co-Chair

Or any of these that people just think are really not a good idea or aren't ready for the kind of focus that we're contemplating, adds or deletions? Clem, I'm curious. When you said there might be things we want to drop off, I'm curious what you were thinking about there.

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

Well, okay. I was going to fuss about the structured SIG because we actually did a big study with Sure Scripts at a local hospital. And there was no need for the SIG to do any kind of reconciliation. And what we found, using Sure Scripts, we found 30 percent more drugs that people were on. But that's a separate issue. But I think that, if adding additional structure to any physician entry that's require, not optional because I think you might want it sometimes, is burden. It takes longer.

Ken Kawamoto – University of Utah – Co-Chair

Yeah. David has his hand up next.

David McCallie – Cerner – ISP Task Force Member

Yeah. I thought I had a comment, but I'm not sure. I think part of the problem, in looking at the list, is it is apples and oranges. And you've got a lump in rate, but it's not an easy way to separate some of these things. So, I'll have to think about it some more. But I think the kind of point that Clem raises is the kind of thing that would come out, if you did dive in and focus on it. So, Clem, I would say, if there's something in that list that doesn't make sense, that's part of what the focus would identify. So, continue to vote for it, but just say you're voting for it so you can down rate some of those things that don't make sense.

Steven Lane – Sutter Health – Co-Chair

Yeah. And I won't take any of this personally. Again, these were ideas on the plane home from DC, mostly.

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

And I like the medication, in general. But the problem with focusing on that is it's the stuff that works the best right now. We've got E prescribing going. The standards are rigorous. The codes are random. So, I think there's additional things that we've got to –

David McCallie – Cerner – ISP Task Force Member

There are gaps.

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

Yeah, I know, but there's a lot going on that we have – NCDSB is working on ways to get best pricing and all. There's a lot of stuff going on there. So, I think it's a very important area, in general. But I think it's not the one in most need of help.

Steven Lane – Sutter Health – Co-Chair

What about opioids, Clem. Say more about that.

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

Well, it's clearly a problem. And there's activities underway about trying to make the ordering process for opioids, which is a very stringent process, work better across Medicaid and Medicare. And that's actually some interest of ONC already. But I don't know any immediate solutions. But it's a high priority. So, we should probably grapple with it and see whether we can think of some great ideas.

Ken Kawamoto – University of Utah – Co-Chair

David has his hand up.

David McCallie – Cerner – ISP Task Force Member

Yeah. Just on the opioid thing, I just had a reason to review the CDC's work on that. They put another grant out to finish their work. And I hadn't really looked carefully. And they've done some very impressive SQL and coding of good practice rules around opiate prescribing and are planning to deliver that as a CDS Hooks alert back to clinicians. And it's deep and thoughtful work. So, I would revisit.

Ken Kawamoto – University of Utah – Co-Chair

If I could just comment on that. I, personally, worked on that project. And we have operational CDS Hooks implementations in our Epic install running enterprise wide. And we do things like do natural language processing on free text because it's fairly prevalent in our institution for opioids, etc. But anyway, yes, I think there's a lot that can be done, in that area. I see Cheryl's hand is up.

David McCallie – Cerner – ISP Task Force Member

I was impressed at the work. Nice job.

Ken Kawamoto – University of Utah – Co-Chair

Cheryl had her –

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

But should we make opioids the primary thing rather than more broad?

Ken Kawamoto – University of Utah – Co-Chair

I guess that's a question should we open opioids as maybe just even a separate top level potential focus. Cheryl had her hand up, she put it down. Okay, David, you don't think so. Okay.

David McCallie – Cerner – ISP Task Force Member

Well, I think you could. I just think there's so much activity in that space already. I don't know what we would bring to the table. I guess I'm skeptical. The PDMP problem isn't going to get solved by anything this committee does.

Ken Kawamoto – University of Utah – Co-Chair

Can you comment on that a little bit further? Because that is a big problem. But can you comment on that?

David McCallie – Cerner – ISP Task Force Member

Yeah. I mean, my impression is that it's dominated by local rules, state laws. And the PDP industry has grown up around meeting the requirements of state laws. It's not something that can be top down mandated without court challenges and all sorts of things. It just seems like an incredibly complicated space for business reasons, not for technical reasons, business and political reasons.

Ken Kawamoto – University of Utah – Co-Chair

I guess, is this group all purely technical? Or is there some benefit in highlighting the fact that part of the reason why we struggle in this space is because every state sort of does their own thing and isn't working together to have a common way of doing things. I mean, when I learned that –

Steven Lane – Sutter Health – Co-Chair

I was just going to say I think that's part of our charge is to provide that kind of feedback back to ONC, and then, allow them to forward that on to other branches of government that may need to work on this.

David McCallie – Cerner – ISP Task Force Member

Well, all you have to do is read the Missouri newspapers, and you'll have a full history of it. Maybe because I live right next door, I know about it. But state legislature won't even allow for screening because of the privacy concerns of one legislator who happens to be a physician. So, it's a political issue, not a technical one. But that's fine, if we can raise that point. I don't think anybody is going to be surprised to hear that.

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

I'd be for it.

Ken Kawamoto – University of Utah – Co-Chair

I guess for me, I had worked in the space for a while on the CDC project, and I didn't even realize, until recently, a lot of the challenges are because everyone is doing their own thing. It just seemed like, maybe for folks who are working in the field, it's obvious. But it was like really like that's the reason why we're struggling? It kind of shocked me. David, you have

your hand up?

David McCallie – Cerner – ISP Task Force Member
No, I'm sorry. I'm done.

Ken Kawamoto – University of Utah – Co-Chair
So, I guess the question of should we, potentially, bring opioids up as a top level, I, personally, am okay either way. Any thoughts? David thought maybe not.

Steven Lane – Sutter Health – Co-Chair
My feeling is that things that we would do for opioids would, potentially, also benefit other med use. We talked about medication care plans, shared decision making. Some of these things are quite generic. As critical as the opioid epidemic is presently, there's a lot of need to improve medication functionality and to support med rec, which was discussed at the outset. So, my personal preference would be to keep it together, at least until we did a deeper dive. I think it would be premature to separate it, at this point.

Ken Kawamoto – University of Utah – Co-Chair
And I do think the fulfillment data is really important, just given that I think it's pretty well known that most of us I think it's like 30 percent of medications never get filled. And for chronic medicines, 50 percent aren't taken, given the medications are such an important part of therapy. That's pretty important information to make available to providers, I think, because –

Clem McDonald – National Library of Medicine – ISP Task Force Member
Yeah. The number I got on that was 10 percent from Walgreen's, but just as a –

Ken Kawamoto – University of Utah – Co-Chair
That aren't filled? Really?

Clem McDonald – National Library of Medicine – ISP Task Force Member
Yeah. When they get the prescription, and they prefill it, and they have to dump it back into their system.

Ken Kawamoto – University of Utah – Co-Chair
Interesting. Or maybe it's for the refill part.

Clem McDonald – National Library of Medicine – ISP Task Force Member
Could be.

Ken Kawamoto – University of Utah – Co-Chair
Yeah.

Steven Lane – Sutter Health – Co-Chair

Okay. Well, I think, Ken, it probably makes sense for us to wind this up maybe even a few seconds early. And we'll prep this, again, as a ballot. And hearing no objections, we will send that out to you, hopefully, in the next couple of days. We hope to collect your input around priorities. Again, I think it makes as much sense as anything to ask people to prioritize their top three, unless people have a better idea. And that doesn't mean that we wouldn't get to other things later on. But we're really trying to, as Ken said, get people to vote with their feet. What are the things that you feel are both most important, that you're personally most interested in working on?

And, again, I'll just remind us where we started, looking for areas that are new and emerging, have not received adequate attention, lack for established or well adopted standards, would benefit from input, have a big impact with the caveats that were shared earlier.

Ken Kawamoto – University of Utah – Co-Chair

Great. So, I guess we'll wrap up a few minutes early.

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

This is Lauren. I just want to check in with the ONC team, Caroline or Farrah, anyone from ONC, any other comments or thoughts before we adjourn? Okay. I think that's it. Sorry, we got a comment? Okay. I think that's it. Steven and Ken, that's all for today, correct?

Ken Kawamoto – University of Utah – Co-Chair

Great. Thanks and I hope everyone enjoys their last remnants of summer. Thank you.

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

The meeting on the slide was not the same as the meeting on the calendar. Is there a discrepancy there?

Ken Kawamoto – University of Utah – Co-Chair

It's not?

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

It shows the calendar meeting, the next one is on 8/31, which is a Friday.

Steven Lane – Sutter Health – Co-Chair

Right. I think that's what my calendar says as well. ONC, can you guys confirm?

Unknown

Yes, I'm sorry. You're correct. It is August 31. That was my –

Steven Lane – Sutter Health – Co-Chair
Thank you for that correction.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. Well, thanks everyone for your time today. We'll talk soon. Thank you.