



Interoperability Standards Priorities (ISP) Task Force

Transcript
November 27, 2018
Virtual Meeting

SPEAKERS

Name	Organization	
Kensaku Kawamoto (Co-Chair)	University of Utah	Co-Chair
Steven Lane (Co-Chair)	Sutter Health	Co-Chair
Andrew Truscott	Accenture	ISP Task Force Member
Anil Jain	IBM Watson Health	ISP Task Force Member
Arien Malec	Change Healthcare	ISP Task Force Member
Clement McDonald	National Library of Medicine	ISP Task Force Member
Cynthia Fisher	WaterRev, LLC	ISP Task Force Member
David McCallie	Cerner	ISP Task Force Member
Edward Juhn	Blue Shield of California	ISP Task Force Member
Leslie Lenert	Medical University of South Carolina	ISP Task Force Member
Ming Jack Po	Google	ISP Task Force Member
Raj Ratwani	MedStar Health	ISP Task Force Member
Ram Sriram	NIST	ISP Task Force Member
Ricky Bloomfield	Apple	ISP Task Force Member
Sasha TerMaat	EPIC	ISP Task Force Member
Scott Weingarten	Cedars-Sinai and Stanson Health	ISP Task Force Member
Tamer Fakhouri	One Medical	ISP Task Force Member
Terrence O'Malley	Massachusetts General Hospital	ISP Task Force Member
Tina Esposito	Advocate Health Care	ISP Task Force Member
Valerie Grey	New York eHealth Collaborative	ISP Task Force Member
Victor Lee	Clinical Architecture	ISP Task Force Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer

TRANSCRIPT

Operator

All lines are now bridged.

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

Good morning, everyone. I'd like to welcome everyone to the ISP Task Force meeting. Just as a reminder, please put your phones on mute if you are not speaking. We will go ahead and start the meeting starting with the roll call. Ken Kawamoto?

Kensaku 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

Good morning.

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

Good morning. Anil Jain?

Anil Jain – IBM Watson Health - ISP Task Force Member

Good morning. I'm 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

Good morning.

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

Good morning. Andy Truscott?

Andrew Truscott – Accenture - ISP Task Force Member

Good morning.

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

Good morning. Clem McDonald?

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

Here.

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

Good morning. Cynthia? I believe she said she may be absent today. David McCallie? Not yet.

Andrew Truscott – Accenture - ISP Task Force Member

I do believe he said that he would be out.

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

Thank you. 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

Thank you. 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

Leslie Lenert? Not here. Jack Po?

Ming Jack Po – Google - ISP Task Force Member

Here.

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

All right. Thank you. Raj Ratwani? Ram Sriram?

Ram Sriram – NIST - ISP Task Force Member

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

Good morning. 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? Cheryl Turney? I believe she is going to be absent as well. Tamer Fakhouri? Not yet. Tina Esposito? Valerie Grey? She said she may be joining us on the phone. Do we have Valerie yet? Okay, we'll circle back. And Victor Lee?

Victor Lee – Clinical Architecture - ISP Task Force Member

Here.

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

Perfect. Okay, just a quick slight adjustment you will note on the agenda for today for the IHMI presentation. We have Matt Menning who will be presenting here shortly. This is just a slight revision from the agenda that was sent yesterday afternoon. So, aside from that I will hand it over to our co-chairs Steven and Ken.

Steven Lane – Sutter Health - Co-Chair

Thank you so much Lauren and welcome everybody. I want to acknowledge at the front end how pleased we are that you all made it back safely from the holiday and that you're here with us this morning. We had a number of planning sessions leading up to today's meeting. And at one point we were considering cancelling because of the holiday, and some competing priorities at ONC, and folks being involved in some other efforts. But we went ahead and left this meeting on the calendar with an intended agenda, which actually did not all come together at the last moment. So, we have a rather light agenda today. So, I apologize for that. We may end up finishing up early. But we do have one presenter that is going to be coming to join us from the AMA Integrated Health Model Initiative.

And I hope that as soon as they arrive – oh, Matt. You are here. Matt Menning is here. So, Matt Menning from the AMA IHMI is going to give us a little bit of an overview of what they do. We've had a couple of meetings with them and have actually, on behalf of the task force, made a proposal to the IHMI related to our current scope of work around referrals and care coordination. So, we'll be discussing that today. One of the other things that we had planned to have today, which we will try to get into our subsequent meeting was a discussion of FHIR messaging standards. This was an issue that was raised by Ricky and others at an earlier meeting – or after an earlier meeting – where we'd been discussing messaging as a component of referrals and care coordination.

We heard a very nice presentation a couple of meetings ago about the 360x standard, which has been in the works for some time and has been built on the direct messaging standard. And it's been acknowledged that the standards world is evolving under our feet and that it may make sense for us to separate out the functionality that we want to support from the standards that are used to produce that functionality. So, we are interested in understanding where standards are in flux. Messaging is one of those areas where there may be a couple different standards that could be used. We've also talked a bit here about the whole issue of message context.

There again there are some competing standards, or perhaps complementary standards, that are being promulgated by different groups within the industry. And I think our job here is not so much to pick winners as to acknowledge where standards exist and where they need to be evolved. Or somebody needs to have a process for choosing between them. So, I just wanted to acknowledge all of that going into this. In the agenda we said we were going to start with the review of our task force suggestions. I don't know that we really have our suggestions ready. That is something that we hope to have done in the near future, but really I think we're still more in a bit of a discussion mode.

Terry, Ken, and I worked on a document which I sent to the team just actually a few minutes ago after cleaning it up a bit. This is the SIT referrals and care coordination common process document. And I don't know if the Excel folks have that document prepared to pull up. But if they do – Terry, are you in a position or a state of mind where you might be able to kind of

walk us through this document and share with the group kind of what you were thinking as you put this together? Or if not that's fine too.

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

Certainly, whatever state of mind that may be. Sure. Let me pull this up as well.

Steven Lane – Sutter Health - Co-Chair

I thought it was a good kind of overview and I think it can help to orient us to the task at hand. And then perhaps we could transition into Matt's discussion of the Integrated Health Model initiative, as well as our submission that we have made to them. Does that seem fair? So, this is actually a different document this one that you're popping up here. The one that I'm talking about is called ISPTF Referrals and Care Coordination Common Process V2, and it is a PowerPoint. Ken, do you want to add to the intro?

Kensaku Kawamoto – University of Utah - Co-Chair

Yeah I think there's a lot of information we've found, and the step we're at now is we should develop some recommendations based on what we know.

Steven Lane – Sutter Health - Co-Chair

So, if we don't have the PowerPoint ready that's fine. We can actually discuss this document a little bit as well. This is a document that we've also been working on. This is the submission that we've made on behalf of the task force to the AMA, the Integrated Health Model Initiative. And as we've discussed here one of the pieces that is really missing – what we heard from the folks who presented on the 360X standard – One of the pieces that is missing is standards for the clinical data that would be optimal to collect and send from a referring provider to a consultant and looking at that from the perspective of each specialty and each discipline.

Of course, this goes beyond medical specialties to therapies, behavioral health, and et cetera. As we have discussed here, we believe this is something that is lacking in our industry is standards to support the referral process. A number of us have worked collaboratively to put together a document that proposes that the AMA Integrated Health Model Initiative take this on and work with a number of other organizations to develop these best practice standards, so that they can begin to help information technology systems including HRs to support the referral process. So, we can kind of page down a couple of times in this document you are displaying now.

This is a Word version of the information that we have submitted on to the AMA website. This gives you a sense of the level of detail that they have asked for. And again, we have submitted this on behalf of the task force. Matt, one of the things that I wanted to know from you – Obviously your website is private to AMA members and participants, but is there any problem with us sharing this document with our task force members who may want to review it in full? That is a question to Matt Meinning.

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

Steve, this is Clem. I would suggest if you're submitting on behalf of the task force, we have to be able to see it.

Steven Lane – Sutter Health - Co-Chair

And that makes perfect sense. I could not agree more, Clem. Officially I am submitting it in my own name as the co-chair of the task force, but that is absolutely true. But Matt Meinning, are you with us on audio?

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

Can you make the font a little bigger?

Kensaku Kawamoto – University of Utah - Co-Chair

Yes, since this is an application I think it's fine to share. There is no – We are not under any nondisclosure.

Steven Lane – Sutter Health - Co-Chair

I think that's true. This is our content that we put on to their website. So, this is something I think we can share with the group. I do hope that we can get Matt off of mute at some point.

Matt Menning– American Medical Association, Integrated Health Model Initiative

Can you hear me now?

Steven Lane – Sutter Health - Co-Chair

There we go. Thanks so much.

Matt Menning– American Medical Association, Integrated Health Model Initiative

I failed to hit one. So, certainly please do share that. And to be clear, you do need to log onto the AMA site, but certainly there is no obligation from logging on and anybody can. So, it is not completely public, but certainly accessible.

Steven Lane – Sutter Health - Co-Chair

Great. Since you are here Matt, and we ended up going down this path of the discussion, perhaps we could segue here into your discussion or overview of the IHMI and what you see as the role of that and perhaps some initial thoughts about this submission and whether you see the IHMI as an appropriate home for it. Would that be acceptable for you at this point?

Matt Menning– American Medical Association, Integrated Health Model Initiative

Certainly. I regret that we don't have Seth Blumenthal with this this morning. Unfortunately he had a prescheduled doctor's appointment. Seth leads the clinical review group, which is one of the three existing sections of the Integrated Health Model Initiative. Their role is (a) to convene docs from across the house of medicine to vet clinical content submissions, as far as their impact, particularly on chronic and burdensome disease states, which is where we hope to focus. We want to have as much impact as we can as quickly as we can. But then also, after working with folks like Dr. Lane to understand the submission and examining those use cases to determine which use data elements are necessary, kind of core clinically relevant data elements to exchange meaningful information related to that use case.

I really appreciate Dr. Lane bringing this submission to us and bringing the work they are doing on this task force to our attention. I know that the clinical review group meets later this week. They convene monthly, and I think Seth particularly is excited about the quality, depth, and pre thought that went into this submission. We will have more concrete feedback once the clinical review group convenes later this week and gets to dig into the work that you have done, Dr. Lane. I am happy to give a high-level overview of the initiative if that helps. I can just talk through it, or I sent a few slides I could move quickly through over earlier today. Either way it works for me. I will defer to the committee.

Steven Lane – Sutter Health - Co-Chair

Since we have a little challenge with getting slides up quickly, perhaps you can speak to it. And if the Excel folks – Oh, those are Matt's slides. I didn't recognize your fingers. Go right ahead then Pull up Matt's slides. Thanks, Matt.

Matt Menning– American Medical Association, Integrated Health Model Initiative

No problem. Can I maneuver these?

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

We can advance the slides for you to say next slide.

Matt Menning– American Medical Association, Integrated Health Model Initiative

All right. So, next slide. We are halfway into it. Essentially, the initiative aimed to improve the quality of the clinical data being exchanged in digital health. The big premise is that we are spending more and more money to collect data, generating more data than we ever had before, but we are still not always able to use that data in actionable ways. We are still missing important pieces of information to capture in a standardized way, particularly to impact population health value based care. So, if we could go down to the next slide. Some of you, I think, have been exposed to the initiative previously. We launched a little over a year ago. We were joined about a month ago by our new leader, Dr. Tom Giannulli, who is our chief medical information officer and lead of the initiative.

With Tom's arrival, we have honed our focus at least for the next year, but the vision broadly remains the same. Make the data that is being exchanged in healthcare more meaningful, and I appreciate Dr. Lane's comment at the beginning of the call about functionality versus standards. I think one of the distinctions that I would like to leave the group with – and we will cover this on the next slide – is a distinction between data liquidity, our ability to exchange data, and data portability, our ability to use that data effectively once it has been exchanged.

To do that, we will bring together as broad a coalition of collaborators as we can. One of our strengths as the AMA is our ability to convene. We will marshal our resources both clinical and otherwise, to ensure that the data being exchanged, is for the purpose, clinically relevant, semantically interoperable, and includes some of those gaps. So specifically, health-related state, pure clinical data, functional information, social determinants of health and goals. Goals that are set both by patient, or a clinician, or a collaboration between the two. If we could move to the next slide. As I said, the clarification that we are making – and I think this has been much needed – is between exchange and use essentially.

So, we are getting a lot better in healthcare at moving information between systems and organizations. Some of the good work happening in government has advanced our ability to exchange information. Other standards developers, and of course HL-7, and FHIR most notably are making huge strides in our ability to move that information between systems and organizations. But in the absence of standards for how we capture and represent that information, we are limited in our ability to actually use it to impact outcomes. The goal of IHMI is to ensure that when we are exchanging data, it is usable across the entire flow of information. It is consistently represented. It is being clinically relevant, and it can be trusted to support clinical decision-making.

Next slide. Please stop me, anybody who has questions. I am moving quickly here in the hope that we can have a more comprehensive discussion once the CRG has vetted the clinical content submission and once Seth can join us. To your initial question about that submission, Dr. Lane, we do have a relatively narrow focus for the next six months. So, as I said we are looking for areas where we can make a big impact, where there is a real need, where there is likelihood that folks in industry will actually adopt what it is that we are producing to improve their products and their customers' experiences. That focus right now is very much around patient generated data and particularly patient generated data emerging from the Internet of Things.

We have an expanded ability like never before to collect information from home monitoring cuffs, from apps, fitness trackers, and et cetera. But very little insight into what data is being collected by those devices and apps, who is deciding if that data is the right data or not, and almost no standards around consistent representation of the right data. In line with work underway across the AMA, we will focus on remote monitoring data as related to three disease states. Hypertension, and we are working there with self-measured blood pressure. Diabetes, and we will start work soon on content for monitoring glucose. And not on this list but coming up later next year, asthma and data collected by asthma sensors.

Across that spectrum, we will be examining not just clinical information – the clinical detail needed to understand the data related to the use case – but also some of that nonclinical but very important information social determinants, functional status, and goals. If we could zoom down past the stethoscope. Why do we think the AMA is the right organization to do this? As mentioned before, one of the things we were founded to do and have done consistently since our inception 170 years ago is convene both the house of medicine and industry. We believe that we are well situated to convene the right players to actually address the problem. We represent the interests of both the patients and physicians.

Our mission of course is first and foremost the betterment of public health. We are essentially an honest broker. We don't really have a horse in this race beyond solving a problem. For many years, we have generated advocacy around the interoperability problem, and I am proud of the work we have done there. For the last couple of years, we started to move beyond advocacy into engagement and the development of the tools to directly address the problem. That is something that we have a proven track record of doing in other aspects of the work that we do here at the AMA. So, we believe that we are well situated to step up and begin to bring folks together to solve the semantic interoperability problem in healthcare.

If we could skip down. To do that – And I repeat myself a little, so I will move quickly again. We believe there are number of critical factors. The convening and collaboration that I have spoken about throughout this brief presentation and exactly the need that brings us onto these kinds of calls. A framework that can be leveraged by content and standards developers who have been doing good work in this space. We are keenly aware – Many of us have worked on these kinds of initiatives or with the medical terminology, vocabulary, and ontologies for most of our careers. We are keenly aware of all of the good work that the folks have been doing in this space.

It is very important to us that we create a framework that allows that work to be used both independently of the modeling that we are doing, but also consistently within that framework. Thus, to Dr. Lane's point, the very detailed set of questions that we are asking as we accept clinical content submissions. Equally important, we think is making the work product of IHMI easy to consume. So, we will be building out software services essentially to create plug and play architecture that allows developers, aggregators, and implementers to easily incorporate this content into their systems. And finally, a joint licensing model. This is addressing one of the key concerns that those of us who have worked in this space have about the difficulty of doing this kind of work.

It isn't too hard for folks to understand the problem. It is certainly possible to raise the funds to start to address it. The difficult question for many years has been how do you create a sustaining business model around this kind of work? Our intent is to do that in a way that sustains not only the work of IHMI, but more importantly, the work of folks who are generating content that again, can be modeled and used within the initiative, or separately, or both. Finally, a very brief overview of the existing IHMI units. That is the next slide. We

talked about the clinical review group, and I guess I have talked a little bit about me. Matt Menning.

I lead engagement for the initiative. The role of engagement of course is to participate in these kinds of calls and reach out to industry. Also, to vet and understand the problems using health data through a platform – the IHMI platform – where Dr. Lane participated recently in a discussion. Those discussions are intended to drive clinical content submissions, and it is gratifying to see that we will be examining one as a result of a recent discussion thanks to the submission from Dr. Lane. Finally, our development team, a group of terminologists and informaticists working in this space collectively for, I don't know, 75 or more years. Those are the folks who actually take the submissions and the feedback from the clinical review group and do the difficult work of modeling that information consistently.

So, as we scale, we can continue to be able to use and understand the data. Finally, a group of folks who have joined us as collaborators, thus far. And you will see as you get toward the end of that list, their focus right now is very much on device manufacturers, where we believe there is a real opportunity to make data entering the medical record much more actionable, reduce clinical variation, and have a real and immediate impact on our ability to make care decisions based on that data. So, that is the short story. I am happy to answer questions. I hope that we can follow up with a slightly broader group from IHMI and have some more concrete feedback on the content submission that we received from Dr. Lane.

Steven Lane – Sutter Health - Co-Chair

Actually Matt, this was great and I think very much gave us a sense. Ricky Bloomfield, you had your hand up.

Ricky Bloomfield – Apple - ISP Task Force Member

Yeah. Thanks, Matt for the presentation. This was very helpful. I was wondering and you touched on this briefly in engaging with other groups out there who may be doing some work in the same area. How would you compare or contrast the work you are doing with IHMI, with the work within HL7 CIMI or you specifically mentioned patient generated data – the work that Open mHealth is doing, other similar groups?

Matt Menning– American Medical Association, Integrated Health Model Initiative

I will start with CIMI because we have had the most discussion certainly with Stan and Susan Matney over at Intermountain and CIMI at HSPC. As I said earlier, the goal is not to duplicate work, but the goal is that we can bring some alignment to the massive amount of good work that is happening out there. There are tough questions there. Not just tough, but forgive me informaticists on the call, but sometimes tedious discussions about how best to model clinical content and which kind of modeling etiology we are going to use. So, we are in the middle of those discussions now. The goal again is to find (a) way to agree to kind of a common standard for how we are going to use and understand clinical content.

Then, some kind of narrowly scoped places to start doing that work. That discussion will center in the short term around hypertension and blood pressure. I think to your specific question, Ricky, relative to clinical content, we are trying to do a lot of the same things that CIMI is doing. The question is how many silos do we want to do this in? And how do we best get that content into actual use? I think we differentiate ourselves a little in that we seek not just to model the content, not just to understand what is clinically relevant, but make it as easy as possible to implement that content and to move frankly at the speed of the market. We are not a volunteer staffed organization. We are not a consensus driven organization.

We certainly welcome and listen to all viewpoints. Transparency is very important to us. I think speed is one of the ways where we hope, I would not say to differentiate, but to advance work that organizations like CIMI are doing. With HL-7, I will distinguish slightly. And I don't know if this a distinction that you were making, but it really does get to that liquidity versus portability question. We are agnostic to how data will be exchanged. We certainly will provide FHIR resources, but our goal is not to facilitate the exchange of data where good work is already being done. It is to facilitate the usability of that data on both ends of the equation. I admit that I am not familiar with the work of Open mHealth. So, clearly something that I need to look more closely at. If you have a few words of orientation for me, that I would appreciate that.

Ricky Bloomfield – Apple - ISP Task Force Member

Sure yeah. Open mHealth has been around for several years now. You can go to openmhealth.org. And their goal is to have an open standard around patient generated data. Their website is pretty comprehensive. And they have a number of groups that are participating including large health systems like Kaiser, Stanford, and UC Davis. It is based out of California. So, it is a little West Coast centric in terms of those who are participating already. Their model is open source and freely available. So, it is getting some traction through that.

Matt Menning– American Medical Association, Integrated Health Model Initiative

I appreciate that, and we look for to learning more.

Steven Lane – Sutter Health - Co-Chair

Ricky, for the group can you share the CIMI acronym stands for?

[Crosstalk]

Ricky Bloomfield – Apple - ISP Task Force Member

Something Modeling Imitative. Clinical... Information Modeling Initiative.

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

When there is a chance, could I make a comic?

Steven Lane – Sutter Health - Co-Chair

Sure.

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

Is there a chance now? There are a couple things to think about in this issue. One of them is that we should mostly try to exchange data living in a machine to not add additional data entry burden on providers, which could be severe. The second thing is that there are existing models for sending specific data elements along with particular requests. This is the case where in most labs, where they have asked at order entry questions that ask for additional data. There is a lot of it in the genetic testing. There is a mechanism to do it, and it is a model to think about. The second thing is that Joel Buchanan at University of Wisconsin has developed a list of important variables in drugs that are linked by problems.

So, he's got for each problem – I think he is working on 50 of them – you can get to the codes, which would identify these important tests and problems for a given disease problem, like ischemic heart disease. So, that would be at a different level. The third thing is my experience when I was still practicing with a computer individual reasons for a referral often had special templates. They were short and fairly easy. So, if you were sending someone for an endoscopy there were particular questions. If you were sending someone for a review of arrhythmias in cardiology there was very specific questions. That will be harder when you get down to that level because you will have a lot more work to do to develop the things. To be aware, this isn't a green field. There are a lot of different things to think about.

Steven Lane – Sutter Health - Co-Chair

Thanks so much, Clem. And I wanted to point I think one of the things that comes up here whether we are talking about CIMI or others is there are a lot of groups who have done work in these areas. As you can see on the presentation in our submission to the AMA, we try to call out a number of groups that potentially could be collaborators in this work. I think one of the things that we perhaps have an opportunity to offer as a task force, is the suggestion of a home, of a convener if you will, that would bring together the other groups to get everybody pointing in the same direction. I think that when OMC supports a convening strategy that often times it can help us move in a positive direction where the industry is kind of heading off in multiple directions.

This again is why we initially turned to the AMA to see if they would be interested in and prepared to take this on. I think, Matt, we heard loud and clear that you guys have the first six months of next year mapped out. And you have some great stuff that you are working on. Patient generated health data is something that we are interested in at this task force, and we may come back to you on that in the future. But I think again the point of this presentation by Matt was really so that people understand what IHMI is so that we can at least consider within our recommendations whether we think it would be worthwhile asking the ONC to potentially support that as the convening home and do that either in word and/or in deed.

Kensaku Kawamoto – University of Utah - Co-Chair

This is Ken. Just to add to that, I think, the potential special value that AMA can provide in this context, especially around the gathering clinical consensus across specialties on for example, what is the information that the cardiologists want sent their way for common referral reasons? And urologists, and endocrinologists, et cetera? That really needs to be done by clinical organizations. I think, the only other ones that could do it are groups like American Association of Medical Colleges. Although that's obviously focused on academic medicine only. And they have a project called Project Core where they are working on these kinds of things.

I think that would be one potential differentiator for clinical professional association kind of groups. I do think one issue that was touched on in the slides that we do need to make sure that this committee understands is that, I believe, this initiative is intending to license the models as the mechanism to recruit the investment in it. That is something we have to consider because we, for example, HL 7 standards are currently free for use and no restrictions really. It might remind you of cases, for example when in the past, where Nomad required licenses and it was not until the federal government stepped in and purchased the nationwide license to Nomad that it became something feasible for everyone to use.

We just need to be aware of the consequences potentially for example if a community clinic wanted to use these for referral purposes, they would have to pay a license fee. Just something we have to keep in mind.

Steven Lane – Sutter Health - Co-Chair

And I think that is something that may preclude ONC from potentially getting behind it depending on what that licensing model is. So, I agree with Ken, we need to understand in much more detail what that means.

Matt Menning– American Medical Association, Integrated Health Model Initiative

This is Matt again. Is this task force the right place for a more comprehensive follow-up on that issue? Because I think it is clearly a very important one and one where we need to gather as much feedback as we can. One of the areas it would be good to do some follow-up, whether with this task force or with a broader or a different group at ONC, is around distribution and licensing of content.

Steven Lane – Sutter Health - Co-Chair

I am not sure this is necessarily the right group, but I think it is the catch 22 where creating standards takes a lot of expensive of people, clinical informatics, et cetera. It is the kind of thing like it doesn't just magically happen. But at the same time, there are certainly barriers for license content. So, it is a tough nut to crack. We want it both ways. We want it free, and we want excellent content. I don't know what the right answer is. Probably a larger issue then something that should be discussed in this task force I would say is the primary

discussion, but probably something that should be discussed probably maybe other venues point to point, et cetera.

I think, illustrative example is just thinking through, for example, what are the widely used standards? And often they are either paid for through licenses or some group has stepped in to pay for it. Or it is such a high priority area that organizations are “volunteering” their employees to work on, which essentially means the companies are paying for the work to be done.

Andrew Truscott – Accenture - ISP Task Force Member

Could I put my hand up in the queue?

Steven Lane – Sutter Health - Co-Chair

Go ahead, Andy.

Andrew Truscott – Accenture - ISP Task Force Member

This is very interesting. I was listening along. I think it is good to see that the AMA is actually taking some leadership here. Even though you can coalesce together the thinking of the raw clinical thinking to actually think through some of these issues. I am a little bit twitchy in it seems like your program of work is addressing themes which are already either being addressed or what others believe have been address. So, you’re starting off with hypertension. You are moving on into diabetes. You are moving on into asthma, et cetera. I wondered whether that was deliberate because there was a concern that these hadn’t necessarily been approached correctly.

And the AMA was concerned that CIMI’s investments in diabetes and hypertension were not actually – you were not comfortable with. I would also throw into the mix the work the OpenAir group has done as well. Ricky threw in mHealth and I would agree with that, but OpenAir, too. I would be interested to know how you are lining up with them. But at the end of the day, the bit that seems to be missing from all of these pieces of work that are going on around clinical knowledge is that a standardized way for that clinical knowledge to be actually moved around. We’ve got historic things such art and syntax sitting over in the HL-7 realm. Are you looking to leverage that or are you looking at something new? Finally, I would be interested to know a bit more about the software asset that you are looking to build out.

Matt Menning– American Medical Association, Integrated Health Model Initiative

I should have taken note of the three questions.

[Crosstalk]

Andrew Truscott – Accenture - ISP Task Force Member

I'll compartmentalize it. Let's start off with is your program work sequence specifically because the AMA has concerns about the prior work being undertaken by, let's just say CIMI, OpenAir, and mHealth?

Matt Menning– American Medical Association, Integrated Health Model Initiative

I can speak a little bit to CIMI, but I cannot speak unfortunately to the other initiative. We started with self-measured blood pressure in large part because at the time, it was a nascent initiative and wanted to build on work that was happening in other areas of the AMA. In our improving health outcomes group here, work has been underway for a number of years in collaboration with the American Heart Association to establish guidelines for self-measured blood pressure by an individual specifically. So, not kind of blood pressure measurement at large, but if you are going to be capturing readings from devices in the home, or in the grocery store, or in the office – what have you – outside of the clinic, what data standards do we need to comply with to ensure that the readings entering the record are actually actionable?

So, I think our concern was less with the quality of work that others was doing, and more an opportunity to build on work that was happening in another area of the organization, and to address what looked like a gap to us in standards for how we model patient generated data specifically. That work of course led us to conversations with a lot of device manufacturers. And what I have heard there is kind of massive variation in how those decisions about what the clinically relevant data to capture and how to capture it are. So, that kind of reinforced for us that there is a need related to sensors and remote modeling devices. So, I guess I would make a distinction there between again, the clinically relevant data needed to measure blood pressure in general, and some additional information that is useful to capture from patients.

This is not, like, real crazy stuff. Was the patient seated? Was the cuff positioned appropriately? Was the patient at rest? A few data elements that we are not currently capturing in addition to some information related to demographics – social determinants of health for that use case. There we are looking specifically at how demographic information, particularly socio-economic information and ZIP Code, has an impact and layering on top of that dual eligibility. How can you use folks who are eligible for both Medicare and Medicaid as a filter on top of that additional information? To summarize, there are two things, remote monitoring, by individuals, specifically. And then as we build these modules out, additional kind of non-clinical information that has an impact on the population.

Andrew Truscott – Accenture - ISP Task Force Member

That was helpful and thank you so much.

Steven Lane – Sutter Health - Co-Chair

Thank you so much. I think we do want to move on. We have given this a lot of depth and again, I really appreciate it, Matt. I think we will wait to hear back from your group after you

have had a chance to look at the submission that we put in. I think, some key questions have been raised especially around the licensing issue and whether if in fact the AMA became the home for this, this would be an appropriate venue given that we want to be sure this content is available for all. More to come on that. We have about a half of an hour left, and we had thought about going through this document that Terry had prepared. It goes perhaps a little bit deeper than we are ready to at the moment.

I think perhaps rather we should stay at a bit of a high level, because we really do want to start closing out this section of our work. So, sorry to kind of change gears for all of you over at Excel, but is it possible to bring up the short one page document that we put on the Google drive? I think you guys have that ready as well. I think what we wanted to do – and Terry thank you for your flexibility on this – was to start to think about how we can meaningfully structure our recommendations around this section. I think – and we use this metaphor previously – that we have waited into a bit of a swamp where there are a lot of folks involved in trying to develop and support standards. We want to be able to provide meaningful input. If you guys don't have that, I could share my screen. Would that be easier?

Kensaku Kawamoto – University of Utah - Co-Chair

I think it might be.

Steven Lane – Sutter Health - Co-Chair

Okay.

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

Steve, there is one correction. They spelled CIMI with as “S” in the notes.

Steven Lane – Sutter Health - Co-Chair

Yes, I saw that. That’s why I asked for that to be clarified. Let me pull up my screen here if I can and try this. Don't try this at home. Here it is. So, I am not going to be able to see the Excel, Ken, so you will need to manage from that side if in fact I am successful in bringing up the Google document. Is that displaying? Can you guys see the document?

Kensaku Kawamoto – University of Utah - Co-Chair

It is, but it is a little bit small though.

Steven Lane – Sutter Health - Co-Chair

It is full size on my screen. So, I don't know what else to do. Maybe I can zoom it. Let me try zooming in a little bit. Did that help?

Kensaku Kawamoto – University of Utah - Co-Chair

That did help.

Steven Lane – Sutter Health - Co-Chair

Okay. Is that good enough or should I go bigger?

Kensaku Kawamoto – University of Utah - Co-Chair

Maybe 150 is good.

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

Steve, this is Terry. This might be a little too brief.

Steven Lane – Sutter Health - Co-Chair

The idea is that as we have been working through this I think, we all agree that the effort of the 360X group is really going in the right direction. Looking at the core functionality that is required to support referrals and care coordination is important. The 360X work, I think, is marvelous. I imagine and I have heard nothing to the contrary from anyone here that – from anyone who feels that is not something that we want to support. But as we have gone through this, what we have realized is that 360X deals with specific pieces of functionality, which we can articulate. I pulled out a couple here. But it also addresses and led us into this discussion about content and the payload of exchange. We spent a lot of time now talking about clinical content that may be specialty specific or condition specific.

But there's also administrative content about prior authorizations. There is metadata that we have discussed and it is called out in 360X. But as we have gone through this, what we have realized is that there may be different standards that are evolving to support some of this. So, one of the key issues or functions that is required to function this kind of referrals and care coordination messaging is message content. We have identified there are perhaps a couple of different standards that the industry is still working out as to how that is going to be supported or would multiple standards be supported. And I just don't think we have the expertise or the time to wade into that.

And then there are clearly standards around the exchange. And as we discussed earlier, 360X was built on direct. And there is clearly an opportunity to look at FHIR or other future emerging standards to support the exchange itself. One the thing that Terry has really pointed out in all this is the key role of governance in all of this. Perhaps, Terry, I will ask you to talk a little bit about that and how you see that fitting into it. This was the kind of structure that we were thinking of for organizing our recommendations. Trying to separate them out into these big buckets, identifying who is involved in each of these, and suggesting to ONC how through their support and/or other policy levers that we could try to move this forward. Ken, do you want to add to that before we have Terry talking about governance?

Kensaku Kawamoto – University of Utah - Co-Chair

No, I think that sounds right.

Steven Lane – Sutter Health - Co-Chair

So, Terry, you had a lot of good thinking about governance here. Do you want to add to this and/or should we pop over to your other deck to go deeper into that?

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

My apologies, I am in the middle of a construction site, and there are saws five feet away from me, which is going to go off intermittently. So, if I get drowned out, Steve, please pick it up. Anyway, on governance, it just seemed – and not because of an oversight, but because we are focusing on a lot of other things – but governance becomes a really critical piece in actually getting party A and party B to be able to exchange and share information meaningfully. More than anything else, just to put it on the list of things that we should look at. And there may actually be standards that support governance that we want to come back and take a look at. I think, that is probably the main point and then it is just a lot of detail.

Steven Lane – Sutter Health - Co-Chair

One of the things that you had suggested belongs inside of the governance bucket was issues of permissions and authorizations. Can you say a little bit more about that?

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

Sure. The 360X project did a lot of very specific work in cited message types and so on. But they put a lot of things out of scope. And out of scope included some the really critical pieces that we need to actually have in place to exchange information. For example, the unique patient identifiers. How do we finesse that? The authorizations under TEFCA – permitted uses, authorization for information exchange, authorization for specific uses by the individual. These are important pieces that have to be in place before we can take someone's data and either share it or move it around. There are a bunch of things beyond semantic interoperability, and syntax, and the message type, and the transport standards that, I think, we are going to have to come back and make a comment on. My friend is working again. I am going to go on mute.

Steven Lane – Sutter Health - Co-Chair

Thanks, Terry. I think, that we have spent a few meetings talking about this domain, and I think, our work is been a little bit more free form than the work that we did on orders and results. But we want to come up with some concrete recommendations around this domain. So, I would be interested in hearing from others on the task force about how you think it might be most valuable for us to structure our recommendations so that Ken and I can draft those and bring those back to you at the next meeting.

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

I think it is going to be really hard. Although I agree with Terry that we need those things. It has been 15 years since we have been trying to get a good patient identifier. Are there any shortcuts that are going to come up in the next year that we can possibly make progress with? I worry about getting stuck on the hardest point and not getting the other parts settled. Individual parties can work out some of the details if they have to.

Andrew Truscott – Accenture - ISP Task Force Member

I think, just on the national patient identifier, my understanding is there are movements inside Congress to move that ball forward. If we can ask the to the guys at ONC leadership to ask for some insight into that because I'm sure Dr. Rutger has a pretty good finger on that pulse. So, maybe we should just ask that question. Because I'm with Clem. We have been trying for decades to get an NPI right. And then we can also look to leverage some of the work that people at CommonWell are doing in this regard. In terms of structure, I would be inclined to have a fairly simple and straightforward lexicon for how we want to go about this. I think, we have identified the different domains of standards.

So, we talked about the syntax. We talked about semantic. We kind of talked about providence and contacts. And now we are talking about governance as well. I think, in terms of having our recommendation structured into those five domains that seems to make sense.

Kensaku Kawamoto – University of Utah - Co-Chair

I don't see any other hands up. Does anybody else on the task force have comments?

Steven Lane – Sutter Health - Co-Chair

Is Arien on the call?

Kensaku Kawamoto – University of Utah - Co-Chair

I do not see him, but Sasha does have her hand up. Please go ahead, Sasha.

Sasha TerMaat – EPIC - ISP Task Force Member

Can you hear me?

Kensaku Kawamoto – University of Utah - Co-Chair

We can now.

Sasha TerMaat – EPIC - ISP Task Force Member

Okay, wonderful. My thinking I guess was I like these domains and I appreciate the work that Terry and the folks have put into organizing it in this way. I think that is helpful. The one thing that I am struggling to parse out of them that might be helpful for our structure in making recommendations is the link to the use cases and the challenges. So, for example one of the

things that we have talked about – a challenge – has to do with sort of identifying all of the actions related to one particular referral episode across different systems. And then that has to do with the functionality, the governance, essentially with the other requirements, and a referral identifier, and so forth.

But then we have also talked about very different use cases like how does the patient stay informed about the status, or the details of their referral, or any steps they might have to take regarding scheduling, or their role in the process. That is kind of a different, potentially related challenge I guess, because the patient will have the same identification challenges that other providers might. But it might be helpful to sort of link into some of these pieces how they address the different players in the scenarios. Does that make sense?

Steven Lane – Sutter Health - Co-Chair

I think it does. I think what you are saying, Sasha, is, you mentioned it at the last task force meeting too, but let's get down to the problem we are trying to solve. And you made it and then based on that organize some of our thinking. Does that summarize it a little bit?

Sasha TerMaat – EPIC - ISP Task Force Member

Yes. I feel like if we want to make a strong pitch to ourselves, to ONC, to the other organizations, the stakeholders that we represent, that consistent implementation of messaging between systems with a shared referral ID is one of the top interoperability priorities part of that pitch will be here is the current pain because we don't have that and here is how this project solves that pain. I think we have talked about a lot of those in our discussions, but we haven't necessarily called it out in our organizational structure here.

Steven Lane – Sutter Health - Co-Chair

I think that gets around – Maybe we could either hand problems within these categories or we could just, at the very top level, state what we understand to be what the big problems are, knowing that there are these various things that are related to it. So, maybe one way state it is that a big problem is that when we want to refer outside of our own organizational bounds, it is very hard to make sure that the information goes smoothly to the referred specialist and back. I think that is probably one clear thing. And another one would be potentially when we want to refer. It is very hard for us to tell which providers have availability, and are accepting patients, and how far you have to look out, and to make it easier to do.

I think, there was a really nice presentation on the 360X project that outlined those current challenges. I think we could sort of point to that. And I think the separate issue that we have been talking about is that when we do make referrals, we don't have well-defined what is the data that we need to send along other than to say in text this is why I am referring the patient and this is what is going on with the patient. Because that is a big point of frustration with specialists, but they don't have all of the information they need to properly evaluate the

patient. Maybe along those kind of lines if we can specify them then the path forward should become clear.

Sasha TerMaat – EPIC - ISP Task Force Member

I think that sounds great to me.

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

I think we are at least to the area of identifying corporate providers and closing the loop. It seems like 360X is doing a lot of work on it. So, natural recommendations, but an issue there is it has not yet gone into many pilots. So, the recommendation there simply could be we think the 360X project should be continued. And we should support moving it forward toward real uses, and identifying what the gaps are, and continue to resolve those. Another recommendation could be that we need to have – Well, we suggest there is an effort to identify what the specialty specific and condition specific referral needs are – information needs are, and to convene a group – ask a group to convene these folks rather it is AMA or AAMC – to start defining those leveraging existing work that could potentially be used in those contexts.

And a third one could be there is a whole new set of standards that are being generated right now. And a potential problem is that we could be trying to put, you know – ask too much of a direct. So, that's a potential question. So, we would recommend further analysis on the implications of continuing down the direct path and whether we need to look toward the latest generational standards like FHIR, like an actual analysis. Because we cannot really expect this task force is going to do that kind of a comprehensive analysis over two calls. We have been talking about it, but that is probably something that needs to be spun off and an analysis done. This is an area that I don't have much of experience in, but as I have been listening, those are the kind of thoughts I have been having about what think we should recommend as a task force.

Steven Lane – Sutter Health - Co-Chair

Ken, is this kind of what you are getting at in terms of the recommendation?

Kensaku Kawamoto – University of Utah - Co-Chair

Yes. I think – Let's see. So, I was thinking around one and three. It was around the notion that 360X seems like the most promising effort going on in that area, and critically neither HER vendors are engaged in it. But it still is limited in the sense that it has not gone into sufficient piloting to know whether it really does work as expected. It probably will, but you know how it is. Any time you do something for real, you learn things. So, it is probably support the 360X effort for one, three, and four. I think, definitely convening support and collaborative development of best practices. And then I think separate from this is an infrastructure need, which is – Maybe a problem potentially is directives being pushed to the limits is sort of a concern that we have been hearing. So, it's almost a fifth problem. Like, technically speaking, that might be an issue. Terry, I see your hand up. Please, go ahead.

Terrence O'Malley – Massachusetts General Hospital - ISP Task Force Member I wanted to suggest that this sounds like a good opportunity for suggesting that ONC put out an RFA to implement 360X as a test app someplace.

Kensaku Kawamoto – University of Utah - Co-Chair

I think we will learn a lot. There is no reason to reinvent the wheel if 360X is moving in the right direction. We should still just keep supporting it. At the same time, we have heard enough concerns about the underlying, sort of, technology of using fax machine influence in healthcare, which is my understanding of what 360X is basically email, secure email, to say somebody should do an analysis. Maybe we recommend that the ONC commission an analysis of the pros and cons of continuing to build down the 360X direct infrastructure versus FHIR. And my assumption is that kind of analysis will reveal that 360X direct, that is a right way to keep going, but these are the things that may cause issues and therefore we should also have a parallel initial investment in what a FHIR-based infrastructure might look like.

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

I think that is a great idea, Ken.

Kensaku Kawamoto – University of Utah - Co-Chair

Thanks, Clem. And Terry, you have your hand up.

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

Just to say that 360X is a great example of a closed loop referral, but it is not the only closed loop referrals we have in healthcare. We have to be thinking about how we can take the 360X platform and rejigger it so that we can use it in transitions of care and even back to lap ordering and results. That is, in a sense is a closed loop referral. And then the grand prize of all is ongoing longitudinal coordination of care, which is a much more complex set of interplay. But it might very well rest on the 360X paradigm.

Kensaku Kawamoto – University of Utah - Co-Chair

So, that would be the notion under closing the loop. Or maybe it's around that infrastructure, clear up our base messaging and then, also, analyze applicability of 360X/direct approach to other closed loop processes such as multi-stakeholder care planning and results, receipts, and delivery. I think, it is getting at this notion that maybe it is the generic problems. The same as why we are having ten different ways to handle the same thing in terms of infrastructure perspective.

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

Exactly. Write that down.

Andrew Truscott – Accenture - ISP Task Force Member

All that we are saying is that the manifestation of point solutions, which have grown somewhat organically over time.

Kensaku Kawamoto – University of Utah - Co-Chair

It is not the kind of thing any one of those groups is really going to spend a lot of effort looking at another approach and think we should have done it that way. But it probably is worth an analysis of what have we learned and is there way that we can start consolidating or learning from these point solutions.

Andrew Truscott – Accenture - ISP Task Force Member

You said the important word there, consolidate, because it doesn't make sense for everything to persist. Is it within our scope to start making those recommendations of where we think consolidation should happen and frankly where we think trimming should happen as well. Is that inside our scope?

Kensaku Kawamoto – University of Utah - Co-Chair

I think it is within scope that that is something that needs to be identified. I don't think that we have the expertise across all of these domains to really say you know what, everyone should move toward FHIR or everyone should move toward Direct – that kind of thing – or HL7 V2 messaging. I think we can point out that that analysis needs to be done. And maybe this task force in three years could make –or you know, the HITAC could recommendations in three years of hey, you know, at this point, let's say that FHIR has become so dominant, why don't we start converging toward it, but I don't think we're there yet.

Andrew Truscott – Accenture - ISP Task Force Member

Well, you know what Ricky and I think about FHIR. Somebody is going to have to push even if we are not making the decision. So, we are going to have to push to get decisions made. Otherwise we will just end up in the quagmire of proliferation of different approaches and subtly different “standards,” which by definition is an oxymoron.

Steven Lane – Sutter Health - Co-Chair

The best way to do that though is actually to start a demonstration project of some kind that can identify the real world problems for this. And to get a community or group that is willing to work together inside of health information exchange, or something like that, to test the 360X approach would be invaluable and that should be done as soon as possible.

Andrew Truscott – Accenture - ISP Task Force Member

I contend that Commonwealth fully believe that they are and Square probably believe they are as well.

Kensaku Kawamoto – University of Utah - Co-Chair

That they are already doing this or that they are the best group to do it?

Andrew Truscott – Accenture - ISP Task Force Member

That they are already doing something similar to.

Steven Lane – Sutter Health - Co-Chair

Just to be clear again, Andy, that Commonwealth's now Carequality Implementers, and that is all one community. It is not either or.

Andrew Truscott – Accenture - ISP Task Force Member

I am not saying it is the exact match. If we were actually, don't get behind 360X, and say okay, we believe with some modernization of the underlying infrastructure, 360X is a paradigm that we should be taking forward then I think we will run up against some active discourse from some of the existing pseudo HIE-type groups.

Steven Lane – Sutter Health - Co-Chair

Do we have any other hands up?

Kensaku Kawamoto – University of Utah - Co-Chair

No other hands up, and we need to go to public comment in a short minute.

Steven Lane – Sutter Health - Co-Chair

I was thinking we could probably do that now, and then come back and close it out after this.

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

Okay. That sounds great. Let's see, operator – or I should say Jackie, can you please pull up the phone number and then operator, can you open up the public line?

Operator

Yes, thank you. If you would like to make a public comment, please press star one on your telephone keypad and a confirmation tone will indicate your line is in the question queue. You may press star two if you would like to remove your comment from the queue. For participants using speaker equipment it may be necessary to pick up your handset before pressing the star key.

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

Thanks. And let me just double check to confirm attendance. I know we had a few others who had joined late. Can we ask either David McCallie, Scott Weingarten, Tamer, or Tina on the line?

Tamer Fakhouri – One Medical - ISP Task Force Member

This is Tamer. I am on the line.

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

Okay. Thank you. There were a few others Raj and Les, I have you guys as well. Operator, do we have any comments in the queue at this time?

Operator:

No comments at this time.

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

Okay, great. Ken and Steven, I will hand it back to you.

Steven Lane – Sutter Health - Co-Chair

Lauren, can you either tell me how to stop sharing or make me stop sharing? I cannot find the control for that.

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

I believe it is in the upper – I think our presentation is different. Is it in the upper left corner, Jackie?

Kensaku Kawamoto – University of Utah - Co-Chair

I don't see it sharing though.

Sasha TerMaat – EPIC - ISP Task Force Member

Yes, he is no longer sharing his screen.

Steven Lane – Sutter Health - Co-Chair

Okay, but I cannot get back to the main screen for the meeting. The last time I did this I had to relaunch it, and I just didn't know if anybody had any other solution.

Kensaku Kawamoto – University of Utah - Co-Chair

Well, I can do any sort of administrative stuff like that. Steven, what do you think? We have about eight minutes left. Should we just continue down the recommendations path? I think this is highly valuable because – Ideal for me is that we can get the gist of the thoughts from the task force and then we can flesh out the wording and then send it back out for feedback if that works. I will share the referrals document that Steven had up a little bit earlier, I think, and then it should work. I think that folks can see that, and I am going to zoom in a little bit. Assuming that the top part is going to start becoming the basis for this sort of unit recommendations and the problems that we are seeing. What else do folks have to add or modify on what we have, because I think that what we will be able to do is to start off of these to formulate for the review, the recommendations.

Does anybody - Terry, do you feel like there's the governance issue and the need for a common governance model along the lines of what TECCA is working on to be put here, or no?

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

Yeah, let's put it as a placeholder. I think that the governance piece is import. I think, it is a barrier for people to enter if they have to develop their own governance structure when it's time. So, a snap-on governance structure like TECCA was proposing to be or that Direct has – Something like that would be very helpful.

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

Would TECCA structure work?

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

I don't know. I hear your point, Clem. I think, it is the concept perhaps more than the structure.

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

I met the governance part of it.

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

Yeah, the governance just baked into the process.

Steven Lane – Sutter Health - Co-Chair

It is a really interesting question. I know we all are waiting to see what comes back with regard to TECCA. I know, we are waiting for a lot of things from ONC for Christmas. Certainly, TECCA depending on how it gets implemented and instantiated, it could potentially provide a

home for the kind of governance we are discussing here. I think that we should remain open to that possibility.

Andrew Truscott – Accenture - ISP Task Force Member

I must confess that I always assume that anything that we would do would line up with the TECCA governance structure. Maybe I was naïve in that regard, but I kind of assumed that is where we would go. We wouldn't advocate for something different. Am I missing something?

Steven Lane – Sutter Health - Co-Chair

I don't think so. But we could in our recommendations certainly put that in as a suggestion that this be governed within the context of TECCA, if we felt that was appropriate. What do people think of that? It sounds like Andy, you will kind of assuming that right?

Kensaku Kawamoto – University of Utah - Co-Chair

I would try it.

Andrew Truscott – Accenture - ISP Task Force Member

It sort of seems to make sense but I'm happy to discuss alternatives if people think it should be something else.

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

I think we should just go with it first. If it fails, okay, but why do it twice?

Andrew Truscott – Accenture - ISP Task Force Member

We have enough problems with standards duplication of efforts and such and the governance one as well.

Steven Lane – Sutter Health - Co-Chair

It is also hard to imagine, as we discussed, where to find a home for the clinical content work. How do you find a home for the governance for the referral and care coordination? That would be challenging since the government is going to potentially support one for us that we can snap into as Terry says.

Sasha TerMaat – EPIC - ISP Task Force Member

I think the challenging part is just endorsing without knowing what we're really talking about it yet.

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

I don't think we are endorsing. We are encouraging. We have to get something done right? We have to get some horses on the track, and then we can back off.

Andrew Truscott – Accenture - ISP Task Force Member

I think we have the presumption that this will be the appropriate model. And we will manage to it by exception to that if it is not will be my suggestion.

Sasha TerMaat – EPIC - ISP Task Force Member

It seems like a reasonable assumption I think we should revisit once we actually have a sense of what the model is.

Andrew Truscott – Accenture - ISP Task Force Member

Absolutely.

Kensaku Kawamoto – University of Utah - Co-Chair

I think we are almost out of time. I am very happy that we seem to have all of the different information that we have learned start coalescing into recommendations for this part. Before we close, I think on just an administrative note, the holidays are coming up. So, there will be some updates to scheduling that we will make sure that everyone is aware of. And then I believe, for this task force, there may be potentially a little break in time as some new guidance might come from ONC for the HITAC in general to review. That is not to say that this task force is going to stop doing work. It is just saying we will be pausing for a while assuming that HITAC members will need to focus on other priorities for the HITAC. Anything else?

Steven Lane – Sutter Health - Co-Chair

We had talked about sending out some homework to folks. One is that we would like to send around the draft of the IHMI proposal or submission so that everyone has a chance to look at that and provide feedback. So, the ONC team will help us with that. Another thing that we had planned to do last time, which I don't think that we accomplished, was that we had posted a referrals and care coordination process flow document that we also wanted to invite people to review, specifically with the mind to identify challenges. I think, this notion of the problems to be solved and some of those problems come to mind when you are thinking to the actual process flow for both referrals and care coordination.

So, I think, if the ONC team can package those up and make them available on the shared drive with commenting capabilities that would be ideal so that we can give people a chance to review those, especially if we are going to have a little bit of a break in our schedule. We do want to come back still and hear a bit more about FHIR-based messaging and the state of evolution of that standard. I am not sure that we need to do much deeper of a dive into IHMI at this point. I think Matt gave us a great intro to that. So, we will put together the

homework with the team and get that out to everyone. So, do we know at this point when our next meeting is? I know we are at time.

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

On the calendar, we have it set for December 11th.

Steven Lane – Sutter Health - Co-Chair

So two weeks from today. Very good.

Kensaku Kawamoto – University of Utah - Co-Chair

But we do not have it two weeks later on Christmas Day.

Steven Lane – Sutter Health - Co-Chair

Very good. So, all other things being equal, we will see everyone in two weeks. Thank you so much.

Group

Thank you. Bye.

[Event Concluded]

Duration: 87 minutes