



Interoperability Standards Priorities (ISP) Task Force

Transcript
January 22, 2019

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

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

Hello, and welcome, everyone. Good morning or good afternoon, depending on where you are located. We would like to welcome you to the Trusted Exchange Framework Task Force of the Health Information Technology Advisory Committee. Today's meeting will be led by our co-chairs, Arien Malec and Denise Webb. I will start the meeting with an official roll call. Arien Malec?

Arien Malec – Change Healthcare – Co-Chair

I'm here.

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

Denise Webb?

Denise Webb – Marshfield Clinic Health System – Co-Chair

Here.

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

Carolyn Peterson. Carolyn? We may have to circle back. Aaron Miri? John Kansky?

Transcript

Operator

All lines are now bridged.

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

Good morning, everyone. Welcome to our first ISP task force meeting of the year here. Happy to have you join us. We will officially call the meeting to order starting with roll call. Ken Kowomoto?

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

Anil Jain?

Anil Jain – IBM Watson Health – ISP Task Force Member

Good morning.

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

Arien Malec? Has Arien joined? Not yet. Okay. Andy Trutscott? Not yet. Clem McDonald? No Clem. Cynthia Fisher?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

Here.

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

Good morning. 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 Junn?

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

Terry O'Malley?

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

Here.

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

Les Lenert? Jack Po? Raj Ratwani? Ram Sriram? 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

Here.

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

Scott Weingarten? Darrel Tourney? Tamer Fakhoui?

Tamer Fakhouri – One Medical – ISP Task Force Member

Here. Good morning.

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

Tina Esposito? Valerie Grey? And Victor Lee?

Victor Lee – Clinical Architecture – ISP Task Force Member

Here and happy New Year.

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

Happy new year. Okay, we will circle back to the roster little bit later at this point. I will turn it over to our co-chairs Steven Lane and Ken Kawamoto.

Steven Lane – Sutter Health – Co-Chair

Well, good morning everyone and happy new year to you and thank you for joining us this morning. We have two primary issues we would like to work through today. The first is to review once again the draft recommendations that we have put together for orders and results well as closed-loop referrals and care coordination. And we've have made some edits based on your and others feedback, and we want to make sure we run those by the task force to get your input and hopefully finalize these for our work from last year and have them ready for our future work to write them into a report back to the ONC.

And then we wanted to revisit the other domains to discuss how we want to focus our time over the rest of our work together over the coming months. We anticipate that we probably have time to dive deeply into two or three more domain areas. And while we did discuss and ballot some priority areas, when we met initially last year, other issues have come forward, both suggested by the ONC and issues that I think have really been coming up in the community at large, and we wanted to revisit that. And hopefully end meeting with a clear, prioritized list of domains we are going to work on next so we can then prepare the first of those for our meeting in two weeks. For those in the public, just before we opened the lines, we were discussing briefly the possibility of having the task force meet in person during HIMS meeting our February meeting, and we will be sorting through that later. Ken, do you want to add anything to the introduction?

Kensaku Kawamoto – University of Utah – Co-Chair

Nope. Sounds good.

Steven Lane – Sutter Health – Co-Chair

Excellent. In that case, we would like to bring up the draft recommendations for orders and results. What you will see in here is that we have... and I think that is probably about as... we can maybe make it a tiny bit bigger but maybe just...

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

Can we have everyone mute their lines, please, if you are not talking?

Victor Lee – Clinical Architecture – ISP Task Force Member

Sounds like somebody is on a train.

Tamer Fakhouri – One Medical – ISP Task Force Member

Yes. But it went away. Thank you.

Steven Lane – Sutter Health – Co-Chair

I hope they get to their destination safely. And then, maybe slide slightly to the right, so we can just lose volume A and we can see B, C, and D more clearly. That should do it. So, again, what we have here is... maybe shrink it to 110% and we can get it all in there. What we have additions in green and some subtractions in red and then I saw Sasha at least had inserted some commentary on some of the fields. But again, what we wanted to do is maybe go row by row and see if people have questions or concerns. You are all, again, invited to review all of this before our meeting today, so hopefully you have had a min to think that through. So, Sasha, I see Jack also has a comment on here. So maybe since Jack and Sasha it looks like you took the time to enter comments, do you want to share your thoughts with us here?

Sasha TerMaat – EPIC – ISP Task Force Member

Sure. This is Sasha. Mine was I think simply a quick clarification. In 2-D which is in the policyholders' responsibilities itself. The final row actually indicates a certification requirement. And it seemed to me this was still talking about CLEA certification of labs, but I wanted to be sure that was intended and maybe add a word to confirm.

Steven Lane – Sutter Health – Co-Chair

Yeah, I believe that is right. That is what we were talking about. So, you are saying to just add the words for laboratories?

Sasha TerMaat – EPIC – ISP Task Force Member

Yes.

Steven Lane – Sutter Health – Co-Chair

Any objection to anybody for that? Great, I am capturing that now and I'm doing some on-the-fly editing and I will put that in the green color so that we can clarify that.

David McCallie – Cerner – ISP Task Force Member

This is David. Just a question. Does condition of payment apply to labs? Is that the right term? I thought condition of payment... well, actually, I admit I initially read it as a condition of participation, but I now see it as a condition of payment.

Steven Lane – Sutter Health – Co-Chair

I don't think that is a formal term, the way the condition of certification is so we both have them capitalized.

David McCallie – Cerner – ISP Task Force Member

That's right. Yeah. I don't know if you can hear me yet, but...

Steven Lane – Sutter Health – Co-Chair

There you go.

David McCallie – Cerner – ISP Task Force Member

Yay. Great. So, both payment and certification would apply. Labs are regulated through CLEA. And it's actually possible through the Once's regulatory power that ONC could regulate the health I.T. used to labs. They haven't exercised that option yet. And then clearly labs are paid by CMS so conditions of payment would apply under the CMS's power as a paying entity. So, I think those are three appropriate certifications under CLEA and ONC are appropriate levers as is potentially the much larger stake in the condition of payment.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

And with that also the condition... this is Cynthia... the condition of participation as well as COP for payment.

David McCallie – Cerner – ISP Task Force Member

Right.

Steven Lane – Sutter Health – Co-Chair

Should we say both? Again, we are talking about the biggest stick, but the point is we are saying this is so important that we think big stick should be available. Should we say the condition of certification and/or payment for laboratories?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

And I also think we need condition of participation which also relates to quality and a value as another leverage and stick.

Steven Lane – Sutter Health – Co-Chair

Anyone object to that? I think the point we are making is we think that all available means should be utilized if necessary, to assure that this coding is done at the source.

David McCallie – Cerner – ISP Task Force Member

Yeah. This is David. I think that is the point to get across, not to worry about which technical regulatory word is used. As Arien pointed out, it's both CLEA and ONC certification levers that are available, potentially available.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

And we also have Medicare and Medicaid levels through COP which is the condition of participation, I'm sorry quality and safety.

David McCallie – Cerner – ISP Task Force Member

Does that apply to labs?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

Yes.

Steven Lane – Sutter Health – Co-Chair

All right, I have captured that. We want to keep moving. Any other concerns about this row one? Again, the changes were fairly nuanced, but they were suggested by folks who were involved in the review. Jack, did you have a comment you wanted to share on row C here?

Jack

Yeah, I just wanted to make a quick comment. So many lab tests have different normal and abnormal values. I think it would be important to have that as part of the standards because otherwise, it would get very confusing when we are interpreting labs other providers.

Steven Lane – Sutter Health – Co-Chair

We absolutely included that, and in fact, Clem did highlight that, and we made an add. I don't think it was in this row, I think it was lower down. But, yes. The abnormal values are absolutely included. Thanks.

Okay. Let's go down to row 3, not all results are sent to clinicians in codified format, with the necessary metadata. I think that is where it goes because that is a metadata issue. Here again, we cleaned up a few extraneous words, and, there you go. Perfect. And added some clarifications. But we do have the bottom of column C, here. We do say require the resulting agencies provide the standardized data including methodology units, normal range, abnormal, etc. as applicable. So that's where that was captured.

David McCallie – Cerner – ISP Task Force Member

I think we make a point... This is David. I think we make the point later on about provenance, but you could consider that is metadata, so I want to make sure my memory is right we mention that somewhere else. yeah, we have it down in a lower row, okay. In other words, not only to understand the metadata to interpret the test but to know exactly which instance of the test you are dealing with, so you don't think you have seen it before when you have and vice versa.

Steven Lane – Sutter Health – Co-Chair

Yes, and David, you added specific reference to the idea of supporting the reference ID's and we have added that at the end, so we'll get down to that. But Sasha, you had a comment in column D?

Jack

Can I ask a somewhat tactical question? A lot of the things that were suggested relies on things like LOINC and SNOMED CT which are not actually administered in the U.S. or by an official U.S. body. In order for a lot of this to happen without folks' sort of falling off the bandwagon, are you guys... it might be important, and I suggest we play much bigger role in potentially take over some of the responsibilities for those organizations. Because I know in the past folks have tried to do this and the problem with that is basically those organizations weren't fast enough that folks started smoking.

Steven Lane – Sutter Health – Co-Chair

Who is that speaking?

Jack

Oh, sorry. This is Jack.

Steven Lane – Sutter Health – Co-Chair

Oh, great. Sorry, I don't have your voice down yet. I think it is an interesting thought. I don't know we are really in a position to recommend to ONC they change the responsibility related to the work. Our task as a task force was to identify the standards that apply and comment on them. Do others share Jack's concerns? We certainly did talk to the folks from Hua Inc. and they expressed to us personally they felt comfortable with their ability to keep up with these requirements. Yeah, this is not reached up to SNOMED.

Jack

This is a case where in many cases the LOINC, clearly LOINC is set up for this. And in many cases both the LOINC and SNOMED subsets are available for this case and aren't applicable or aren't used in all cases. Also, the U.S. federal government generally has standing with on it too, as well as LOINC so there is federal participation, both through the agencies and at the administrative level on both of these agencies. but what we are calling for isn't so much the creation curation of new codes, although that is clearly required from time to time, but the actual use of the codes currently created.

David McCallie – Cerner – ISP Task Force Member

This is David, but it is not out of the question to urge proper funding of these entities so they can generate timely updates. I think they are sometimes limited by funding. That could be a role for the government. We don't need to reinvent SNOMED, please. But we can continue to fund that and LOINC is probably in more need than SNOMED.

Steven Lane – Sutter Health – Co-Chair

So, Sasha introduced a comment regarding our suggestion around the topped metric for electronic laboratory receipt. Her point is this is something outside of the control of the providers and therefore on some level, it doesn't make sense to hold providers responsible. Having said that, data could be collected to through MIPS to inform decision-making and policymaking around the desirability of moving this data but Sasha, your final suggestion was to actually consider removing that third to last bullet about the electronic laboratory receipt in the MIPS payment program. Do you want to add to that?

Sasha TerMaat -- Apple -- ISP Task Force Member

Yeah, no I think you did a great job of summarizing. I know from extensive experience with previous MUMs or meaningful use measures that the further the provider is from directly being able to impact a measure, the more frustration and problematic the measures have become. If there is a clear provider action that they can take to improve a particular outcome, a measure seems to work well.

In this case, if a provider is contracted with the laboratory that is not vending results with the metadata that would be ideal, there is probably indirect things maybe the provider's organization can do in terms of lab contracting when it is up next for renewal or considering different agreements with other labs. But that's is pretty distant from an individual MUPs participant. And it wouldn't be like every time you get a lab action it would do it. It would be like once a year sort of contracting consideration. So, I don't think it makes a good MIPS measure. I think if we want to gather data on the current state, there is maybe a better method because I feel like it is ill-suited to this MUPs mechanism that is proposed.

David McCallie – Cerner – ISP Task Force Member

Isn't this a NYM writer's nominator problem? I think what we are calling for here isn't that a provider should be responsible in cases where the lab doesn't have the standards-based or result reporting

available, but then in cases where the lab does have standards-based result reporting available, the provider should be held responsible for using standard-based results reporting. It is an ecosystem problem. And if people are topped out on an electronic receipt mechanism but the electronic receipt mechanism is falling short in the ways the task force has already articulated, and the standards in question actually address many of the clinical concerns this task force has articulated, I think what we are asking for is driving a little more of an ecosystem-based approach. That would be the intent of a certification measure and then the way to address the problem, Sasha in your note, is a numerator denominator issue where you have exclusions that are available for labs that just don't report out in a standard based way.

Sasha TerMaat -- Apple -- ISP Task Force Member

I don't know how to construct the denominator for that measure. And I think it would be significantly problematic from a reporting perspective. But so, I guess, if that is the intent, I think we need to refine the text, there, so that intent would be understood by others reading it. I don't know I understood that from what was in the bullet points. And I still I guess have reservations that in terms of all the things we could measure, and the complexity of costs associated with measuring them, defining the denomination that case is quite hard. The numerator when you have got the metadata is easy. The denominator when you could have gotten metadata but didn't is very hard. There might be cheaper measurements like just all lab results and when you have metadata. And we figure for monitoring across the industry without the overhead of including such a measure in MIPS.

Steven Lane – Sutter Health – Co-Chair

What do you think of the language I put in there just now which is a slight modification, Sasha of what you suggested?

Sasha TerMaat -- Apple -- ISP Task Force Member

I don't understand how it works in MIPS, frankly. MIPS is a provider-based program. I don't know how to define it in a way that a provider would meaningfully make a difference about what theirs is, so I guess I am still puzzled.

Steven Lane – Sutter Health – Co-Chair

Did you see my language, consider a new measure for MIPS around how frequently results received with associated metadata are integrated into the local medical record?

Sasha TerMaat -- Apple -- ISP Task Force Member

What is the denominator of that measure, Steven?

Steven Lane – Sutter Health – Co-Chair

Results received with associated metadata.

Sasha TerMaat -- Apple -- ISP Task Force Member

And what is the numerator?

Steven Lane – Sutter Health – Co-Chair

When those results are integrated into the medical record.

Sasha TerMaat -- Apple -- ISP Task Force Member

Was the difference between receiving a result and integrating a result?

Steven Lane – Sutter Health – Co-Chair

I think that will be tricky with labs. A lot of them are automatically integrated. Right, automatic is fine, right? What is it we should even say, automatically integrated?

Sasha TerMaat -- Apple -- ISP Task Force Member

But is the problem we are trying to solve here automatic integration? Or is the problem that we note there is some quantifiable amount of times where we are not receiving the metadata that is desired.

David McCallie – Cerner – ISP Task Force Member

I think Sasha's point, which is a good one is the construction the numerator-denominator in cases where the lab has available to standards-based report but isn't sending it with EHR isn't requesting it or set up to request it. That is a problem that requires somebody on the back end to do manual work to construct a numerator-denominator rather than something EHR can construct automatically on behalf of the provider. So, it drives at least some level of administrative complexity to administer the method. The larger point, I think it is appropriate to note that, I think the larger point that in cases where the lab has made available – let me back up.

As I think people remember when were rolled out electronic lab reporting as a measure under meaningful use, part of the perspective is if the EHR is already receiving information electronically that we aren't going to require them and retrograde and retrofit. And I think what we are running into is in many cases EHR's are not using the state-of-the-art that's available through the lab or the lab doesn't have any incentive or is it driving a behavior from the provider to upgrade that or ask the lab for using a standards-based interface. In those this case is as the task force documented, there are insularities, there are issues the latest standards addressed that aren't addressed by the lab reports. That is really the conundrum we are trying to address, and I take Sasha's point this may be too blunt of an instrument.

Sasha TerMaat -- Apple -- ISP Task Force Member

If we want to put something in MIPS it should be something providers could be making a difference in action by action. I don't know that I see this here. So, I don't know MIPS is the right mechanism though I certainly think there are other steps that are useful to be taking.

Steven Lane – Sutter Health – Co-Chair

So, what I'm hearing, and again in the interest of time, there's a lot we want to accomplish today is to go ahead and remove this line that begins reconsider topped out here and leave it at that. Any objections?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

This is Cynthia. The question I have, from a layperson standpoint, from the consumer side, is ensuring the laboratory data is in a machine-readable format that would be analyzable, accumulated and trended by any open API to provide analysis and then also access. From the consumer hat as we look at these, I also just want to flag the need to have access to their own data and the accumulated data as a comparison to know the norm. But in light of it being also free of charge and analyzable and readily accessible to the patient.

Steven Lane – Sutter Health – Co-Chair

Yeah, I think we covered that in our first bullet. We are clearly expensifying that this is for providers contributions. So, thank you, Cynthia. We really kept that very much at the forefront as we've gone through this. In fact, the next row is about that, making results available to patients and proxies to effectively view, receive and utilize. So, here again, some minor changes to the language. I didn't get the color coding quite right.

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

Hey, Steve, this is Clem. I got on late, but the screen is really small.

Steven Lane – Sutter Health – Co-Chair

I hear you, we are trying to see each row. I don't know what we can do and still keep it moving at a reasonable clip here.

Kensaku Kawamoto – University of Utah – Co-Chair

H.R. maximized? There is an icon at the bottom of the screen for you can still see who is participating, etc. It should allow you to maximize, I think.

David McCallie – Cerner – ISP Task Force Member

The other option is to look directly at the Google doc, because you are updating that in real time, and you can see that and zoom that to your heart's content.

Steven Lane – Sutter Health – Co-Chair

Clem, I think we need to keep in where it is and hopefully on yours and you can see it.

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

Well, I would like to bring in two other things. The business about tapped out is completely wrong and letters from the laboratory industry documenting how it is wrong. So, don't let go at that. It wasn't tapped out. It wasn't close to topped out.

Steven Lane – Sutter Health – Co-Chair

The point was more that it really wasn't in the control of the provider themselves to be able to change that, so we are leaving that on the laboratories, and I think we have been very strong about the requirements.

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

And there's one other point about a big distinction. The commercial act by a large does a good job. They have to code it and structures in the hospitals by a large do a lousy job. It is ironic because of commercial labs are not under the power HIPPA, so that's something we should really emphasize. And I don't think we have to have the latest and greatest standard, you know D-2 on up if they put the codes in there it will work just fine, and everybody can translate them. So, the emphasis should be on getting a good structure on one of the more recent standards and putting pressure on the hospital lab deliveries.

Steven Lane – Sutter Health – Co-Chair

And we do include all resulting agencies specifying whether it is the hospital for the provider's office or laboratory.

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

Well, the hospitals are 60% of the volume these days.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

Especially as doctors' practices are self-referring within the hospital system. Could I add on to the patient aspect that I don't see anywhere this data should be free of charge to the patient? They should be able to get these results analyzable in free of charge and I don't think we are very clear with that.

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

No, no. I think that is already available, we just emphasize it. I think we have said that in some official standard. Not we, but HIPAA or one of the regulations say that.

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

I think we need to be clear. I think it is available free of charge but might not be accessed re-off charge. We can say mutual access, but there reasons now why access there might be a charge for, but the actual availability is free, does that make sense?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

No, I don't think it makes sense. The issue is this patient has paid for the medical service. When we go to the bank, we don't pay for electronic access to what our bank balance is or the price in the grocery store. So, we really need to put this into a market economy where the laboratory, the name and the data, information critical to the patient's health and paid for by the patient's co-pay, their deductible, their taxes, and their medical insurance. Four times it's paid for and it is still not accessible to the patient. We really need to make this data accessible because it is about the quality and safety of their health.

David McCallie – Cerner – ISP Task Force Member

Just to confirm the current regulatory state, the OCR, the administrative body for HIPAA has confirmed 1.) in cases where an electronic format is readily available and requested by the patient. In all cases under HIPAA, the provider has to provide effectively at cost, and we are talking about a case where the marginal cost is pretty close to zero. 2.) OCR has also confirmed patients have the right under HIPAA to access their lab information and that is a HIPAA access right. I think both of these cases of API requiring providers to make available any PI is addressed under both MIPS and meaningful use. The cost and access issues have clear guidance under OCR and then patient access to labs has clear guidance under OCR. All of those things are happening the way OCR intended and practice. It is an enforcement issue and not so much, I think, a policy issue, although it is worthwhile to reconfirm the policy goal as Cynthia notes.

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

That's what the reg says, not just getting the lab results through your doctor, you can go directly to the lab to get them.

David McCallie – Cerner – ISP Task Force Member

I did make an addition, Cynthia in the second line, there, free of charge, does that feel right?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

Thank you.

Andrew Truscott – Accenture – ISP Task Force Member

That is not the policy though, is there?

David McCallie – Cerner – ISP Task Force Member

Well, it is listed as a recommendation.

Kensaku Kawamoto – University of Utah – Co-Chair

Are we really saying free of charge? Or, if HIPAA basically saying basically at cost, electronically it should be close to free, but...

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

The patient gets access to their care it's being, you can actually consider information blocking because when patients are held up to get access to the data and for a cost on something that has essentially no cost, we are really hurting the system. So, I think wherever we can be overt about delivering this because the patient has already paid for that service, this is their results.

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

Cynthia, if we qualify that saying they got the electronic data free of cost, I think their concern if the Xerox is 500 pages, there could be a cost. And I think that would work if we qualify it under electronic data and not data in any other form.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

I think the one thing that is going to happen if it is free of charge to the patient to get their information, when we go in a restaurant, we get a menu and we are not charged to look at the menu and we get the prices in what we are ordering. So, I think the same applies to the patient. I think this game playing of charging and withholding access, we have an opportunity to change it in our recommendations. And I would strongly encourage us to be practical because it has been paid for and then some.

Steven Lane – Sutter Health – Co-Chair

One way to approach this if I may, in the second bullet make all results in the EHR available to patients via APIs. We are saying all results available electronically, I guess the EHR is electronic, but we have got the problem of scanned results. We could add free of charge to the second bullet instead of the first bullet. Does that sound better?

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

That sounds good to me.

Kensaku Kawamoto – University of Utah – Co-Chair

I think a potential issue here is that there is a value add, what would this mean if this becomes policy? For example, if Apple makes lab information available in their Apple iOS and in order to use that you need to buy a device, is that now no longer free because you have to buy an iPhone?

David McCallie – Cerner – ISP Task Force Member

This is about the providers.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

This is about the results and the report of medical care. I don't think there are unintended consequences because every other industry on the planet provide post results and they don't charge you for the paper and go through hurdles to get it.

Andrew Truscott – Accenture – ISP Task Force Member

That's not quite true. Because if I go to my bank – you have a good example and I agree with the principle entirely. If I go into a bank and I go to my banking app and I can get all my bank account information, all my statements, all my mortgage information. But if I go into the bank and say I want a hard copy of all my statements they will say absolutely. We will charge you one dollar and a quarter for that. It's nominal, but there is a slight charge.

David McCallie – Cerner – ISP Task Force Member

But, Andy, here we are talking via API specifically.

Andrew Truscott – Accenture – ISP Task Force Member

I agree, and I understand what we're talking about. The electronic access you shouldn't be charging for that and I agree with Cynthia. Whether there is an actual incremental cost to provide that access, then that doesn't seem unreasonable and that is what volume the policy is.

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

Steve, I think you have come down a good position.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

If I am at the lab and I come out with a very necessary result, are with opening the window to say I can't get a copy without paying for it and it is a one-page result of my lab test? Let them go fight about it but I would rather have it be free of charge and this is the result of your care than to be pushed.

Steven Lane – Sutter Health – Co-Chair

You have made a clear point, Cynthia, but I think we have some pushback saying the electronic access can reasonably be expected to be free of charge via the API but then trying to do that – trying to say that suddenly paper copies aren't going to be charged for goes beyond the reach of our group, I think.

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

It's not the issue of the lab test you got today. It's someone comes in and they want a thousand-page medical record copied because they are going to do a suit or something like that. Going to do whatever. Those are expensive.

Andrew Truscott – Accenture – ISP Task Force Member

[Inaudible] [00:37:22] but not the hard copy standards.

Steven Lane – Sutter Health – Co-Chair

Don't we think API should be free? That is what we got, let's move on.

Kensaku Kawamoto – University of Utah – Co-Chair

One thing we have seen is the OCR guidance may not apply to groups like lab core or Quest. I believe Quest was charging for electronic access to data from a consumer perspective via their website. I think it was data more than a-year-old which could be a lot of data potentially. We went to raise that here

that would be included, or do we think that is outside the scope of this given they may or may not have a direct relationship with the consumer at the time the lab was performed?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

I think anybody that provides this for consumers should provide the data free of charge, the information free of charge electronically. I think we should include all entities, so no one gets an out to play games behind scenes.

Victor Lee – Clinical Architecture – ISP Task Force Member

[Inaudible] I would say I am generally supportive it needs to be free of charge to prevent information blocking, but things like this can easily lead to unintended consequences where you block any value added completely. You could easily imagine an EHR company figuring out how to display the data better, how to be more consumer-friendly, and now they have no business model.

Steven Lane – Sutter Health – Co-Chair

Yeah, I think in this case the regulatory framework is actually already there and, in our guidance, or our commentary we should point back to that regulatory guidance that is already there. That readily available standards-based formats including HL-7 fire that are made available fall within HIPAA access requirements as regularly available form and format for the patient. I believe that addresses the concerns – I believe the existing policy is the concerns stated. As I noted, there may be an enforcement issue in the sense that whether it actually works in practice the way it is designed and the whether the policy guidance expresses are a different issue from whether the policy guidance is correct.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

I just would say that I think we need to be overt about it as a recommendation. I think we have an opportunity to be very clear and be overt about it. That would be my recommendation as a big favor to market place. Especially as you can imagine that consumers are now having 30% or having high deductible plans, any incremental price that is not necessary is painful. So, I think we can take the high road and add it.

Steven Lane – Sutter Health – Co-Chair

I would like to take a moment, here, to acknowledge that we are halfway through our meeting and we have gotten through about 15% of what we hoped to accomplish. And I think this is a really valuable discussion and suggests to me we need to consider taking more time to be sure we get this right. What I would like to propose is that we actually stop this discussion at this point because we have a lot of really great ideas. I think Arian, inserted some language. And what I'd like to do, unless Ken you object, would be to shift our focus to the prioritization of the coming work. Because we want to plan our work ahead and keep moving along well with also finalizing these recommendations. So, Ken, would you feel comfortable if we paused here and thought about another time to come back and hammer through these issues and shift over because we do have some guests that came?

Kensaku Kawamoto – University of Utah – Co-Chair

That sounds perfect. Let's come back to this one.

Steven Lane – Sutter Health – Co-Chair

Thank you all for that engaging conversation. Arian, I'm going to ask you to help us out with some language that captures the sentiment of the group here. And I would like to shift over if we can back to our agenda and bring up the list of the five domain areas that we invited you all to consider going into

this discussion. And again, I hope nobody feels cut off. We want to make time to have that discussion in its full flavor.

Some of these have been discussed before, specifically the evidence-based disease management, medication, and pharmacy data exchange, but others have really come up through discussions we have had here, with members of the task force and others. Social determinants of health are an area that is getting a lot of attention now and at least it seems might benefit from our engagement. Prior authorization and price transparency have come up in the two domains we have already addressed. But ONC, in particular, is interested in potentially having either the input of this task force or the entire HITAC to weigh in, especially around authorization.

So, what we wanted to do was briefly go through these and clarify what each entails or what we think they entail. I'm talking very brief, here. No more than five to seven minutes on each one. Then we have invited you to rank them in the Google Doc. And we ask you to do that ahead of time and our hope is you have done that and if you want to make changes as we are going through, we would like to end up with the ranked order at the end. I'm not sure we're going to be able to accomplish that. With that, I would like to invite Ken to discuss evidence-based disease management, which is one he has given a lot of thought to so we can all understand what we are talking about here.

Kensaku Kawamoto – University of Utah – Co-Chair

Sure. I'll be fairly quick. I proposed this one since there is a lot of evidence patient don't get all the care they should. I think the latest evidence is around 50% of the known best care is delivered to patients in the U.S. For example, Midlands work with the Rand Corporation I believe in *the New England Journal* study. The idea is we have collected all of this data. Much of it is electronic now. What is the purpose of it? One important purpose is to make sure patients get the best care that the evidence says. To do that, we need a few things.

I think one of them is data if it is already collected in electronic form to have it in a standards-based form. So, it's things like lung cancer is the number one cause of cancer death in the country. There is a known recommended screening program from the U.S. preventive services task force estimated to save more lives in breast cancer screening. The current national screening rates are under 5%. So, the idea is to take his other data elements, the patient's past history and if it's collected already in structured form and it's needed for this kind of decision making to make it available as a standard data element. Another example might be for diabetes management. You need to do monofilament foot exams to make sure the patient is not getting desensitized in the toes and not leading to ulcers and amputations. I assume almost all EHR's are collecting that form, but it is not in the standard the way it is being pulled out. So why don't we standardize around that? And there are of course related things around things such as how to use integrated EHR. That is my plug for evidence-based disease management.

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

When you say put in the standard, what do you mean by that?

Kensaku Kawamoto – University of Utah – Co-Chair

For example, with the lung cancer smoking history, etc., the data elements needed would be things like, when did the patient start smoking, or state data or to a stage. Half your information, in our EHR, it is all in the structured form, but it is not in available in the prior APIs or really any other APIs natively and it's not part of the U.S. for fire specifications. So, we actually built the interface and were using it in

production for lung cancer screening purposes. And the idea, for example, is to say if it is being collected, let's define U.S. core fire profile around the smoking, and add in beyond, are they a current smoker, are they a former smoker, a never smoker, that kind of information, and to likely have two aspects. To say if you are collecting it in structured a form, this is how we want it to be provided. If you are not and you decide to collect it, then we recommend you make it available. I don't think we want to get into the part of saying you should start collecting the structured form or mandated. But it certainly makes sense if we are collecting the form recommending how to make it available in the standard approach.

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

But Ken, Ken, these are just observations and all you need is well, the LOINC codes or something else like it. Plus, it's a well-developed field and there is a lot of arguments by the experts over what should be collected I think they have to.... somehow, we have got to get to that. One of the values is how soon and you wake up do you have to get a smoke? That is one of the best indications of addiction. So, I don't think just saying this form one group has developed should be used. Is going to need some discussion.

Kensaku Kawamoto – University of Utah – Co-Chair

I agree. At this point but what we are saying is we are about priority use cases. I'm just arguing one of the priority use cases using the data in a way that allows us to apply the best evidence. In terms of what data points are needed and what those should look like, that would not be something we would probably doing this task force, we would be recommending how that could be done because right now there is no clear pathway.

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

Well, I think we need to recommend convening some groups that have expertise.

Steven Lane – Sutter Health – Co-Chair

So again, the point Clem is to simply identify the issue so we can vote on it, not to address the issue here. So, the next one we're going to discuss is, to move on. to social determinants of health. We did invite Al Taylor from the ONC who has been doing a lot of work coordinating the ONC's support for this domain and we wanted to invite Al to briefly discuss from his perspective the state of evolution of standards relating to social determinants.

Al Taylor – ONC

Thank you for the invite and the opportunity to talk to this group about it. I think as everybody knows, social determinants are a key determinant of overall health and health outcomes. And by addressing the social determinants, including intervening to improve the social needs of a patient has a major impact on health. In fact, many folks say it has a more important impact on overall health and health outcomes than specific clinical interventions.

From a Health IT standpoint, to back up a little bit, there is a lot of instruments available to screen for a variety of social needs. The National Association for Community Health Centers has prepared a tool which is very widespread use. Accountable Health Communities have a new health-related social needs screening instrument and organizations like Health Leads have social needs toolkit. These are just a couple of them. There is a lot of other surveys and instruments available to assess or screen for the social needs.

From a Health IT standpoint though, there is a big gap because not only is there poor representation of all of these screening tools within healthcare vocabularies and standards, there is not a good agreement on which is the best tool to use in which setting. Because they are not represented using these vocabularies and coding systems, it is difficult to capture them in a way in the electronic health record that can leverage the capabilities of Health IT and to make them interoperable so you can capture them in proprietary format and not be able to exchange them in any meaningful way with another party including the patient.

There is a lot of work that has been going on in the community, the community of the social needs screening instruments, users that have started to close the gap. And this is been occurring over the last four years or so since the National Academy of Medicine put out their social needs report about integrating it into the health record. And as a direct result of that, ONC put social determinants into their 2015 certification rule. Also, more recently, ONC has proposed social determinants in the element they are in be considered for potential inclusion in the U.S. Core Data for Interoperability. But those data are... The reason that is not been proposed something more advanced than that because there is a gap between the concepts and the codes, and they are just simply not usable in Health IT in a meaningful way right now.

I did want to highlight a recent paper, I think it was in 2018 which highlighted the gaps in three different areas of social determinants including screening which involves the assessments. I'm sorry, this screening instruments, assessments and diagnosis which is more diagnostic codes and then also the interventions which are sort of the treatments for these social needs. Whether it is food assistance, housing assistance, etc. So those three parts of social determinants, the exhibit a very large gap of what is available to screen and what is available in Health IT.

They also published as part of that they also published a compendium of existing codes. They did a pretty extensive scan of the existing codes in those three realms of screening assessment and intervention. And that actually is a published compendium through the research network that is coordinating a lot of its effort in the social determinant's community.

So, I think being able to capture and share and use and leverage Health IT around social determinants would have a very large impact on the ability to communicate a fuller picture of the patient and be able to use those data for improving care.

Steven Lane – Sutter Health – Co-Chair

Thank you so much, Al, that is a helpful summary. And again, Clem, if I can just say, the purpose of these discussions is to not dive into these areas but to just clarify the scope of the domain that we are talking about so each member of the task force can prioritize these issues so we can determine what direction we are going.

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

He mentioned three or four things I that I was hoping we could get, you know, because the real scope, looking at the sample of surveys. And these are surveys, Al, really aren't they all?

Al Taylor – ONC

Yeah, these are essentially paper-based instruments. Most of them are pretty well validated. Some come from federal programs or private research programs. But these are validated instruments that

have scientific backing and association with outcomes, but they just can't be used in health IT right now.

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

But if we could get a look at them, all it would take would be choosing them and then asking the industry to use it. Choosing is always hard, though.

Al Taylor – ONC

Choosing is, yeah. Because the particular need for a particular instrument is sometimes specific to the setting. In some settings, it's just – there may be more than one tool needed to food insecurity or insecurity housing insecurity because of the particular setting in which it is used.

Steven Lane – Sutter Health – Co-Chair

Again, we are going deeper then we have time for today. I want to move on. Thank you, Al, that was a great summary and I think people understand what we are talking about here. The challenge for the task force members is again to understand the domains so you can prioritize them. And I see is we are going along, people are adding their priorities. So, I want to get through the list so we can maybe ask some questions at the end so Al, if you could stay with us, that would be great.

Al Taylor – ONC

Sure.

Steven Lane – Sutter Health – Co-Chair

Cynthia, did you have something you wanted to slip in there?

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

Yes. I just wondered as we looked at social determinants as a task force, just as a role of the task force just to consider, I'm going to tee it up as a flag for perhaps future discussion, is there is a dark side to that metadata on social determinants that can be potentially remarketed or utilized as big data on that individual for dark purposes of access. I just went to tee it up in how we look at it in light of transparency to the patient in knowing as it affects their privacy as it affects the potential of them being marketed to or that data being shared for not the original intent was. So, I just want to throw that out there.

Steven Lane – Sutter Health – Co-Chair

Thank you. Thank you, Cynthia. If we go into that area, we will be sure to go into that. The other three domains on the table are again prior authorization which as we know a lot of people are working hard on using different technologies. To medication and pharmacy data, we do not invite anyone in particular to discuss these. Price transparency, Cynthia, is something you have emphasized in the number of our discussions, talking about the net cost to the patient. I think most of us do understand what that means and there are a number of vendors who are doing innovative work in bringing price data all the way to the point of decision making for clinicians. We can certainly understand what they are doing and what standards they have been utilizing and weigh in there in terms of over and above what we have already suggested.

Prior authorization is something that came up as a key issue in the interest of the ONC after the recent ONC meetings late last year. Lauren, I know I didn't prep you for this, but did you want to comment on

the ONC interest in prior authorization and where they think either this task force and/or the HITAC could add value could be added there

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

I think from the ONC perspective, there is a lot of ripe opportunity for this particular task force to address this. We know prior authorization certainly has a tie into the ongoing work, not only of this taskforce, but the committee. But perhaps maybe starting with the technical aspect of prior authorization that we would like the task force to address. We also hope an upcoming broader HITECH committee to start to engage the rest of the committee in terms of where their thoughts and approaches. And then as we start continuing those discussions, hopefully we can focus in and narrow for this task force to carry on that work. But we are certainly open to suggestions from task force members as well as from the public as we begin to tackle this.

Anil Jain – IBM Watson Health – ISP Task Force Member

Just as a placeholder comment, standards, and systems for medical prior authorization for medical claims and are different than those for prior authorization for pharmacy claims. And so, it might be worthwhile just making sure we keep note of that and potentially address different recommendations in each of those areas.

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

Thanks. That is a very valid point. I think we have already started to see some initial guidance and recommendations both from within the government and private sectors to keep that in mind. Thanks, Arian.

Kensaku Kawamoto – University of Utah – Co-Chair

I see David's hand is up. David, do you still have a comment or...

David McCallie – Cerner – ISP Task Force Member

Yeah. Just a general comment particularly about prior authorization and the medication and pharmacy data spaces where there is a ton of activity underway. I guess the broad question is does this group think it's worth adding to that existing conversation or should we focus on areas that may have received less attention? On an FCC note, it's really a what does HITECH want out of us? If they want us to weigh in on the existing work and encourage the stuff we think is doing well and likewise, it makes sense to take on some of these have a lot of activity already, but it's a strategy question, really.

Kensaku Kawamoto – University of Utah – Co-Chair

Yeah, David, I have reached out to Steve Posnack to ask him that very question. I haven't heard back from him, but I think you make a really good point. We are here in the service of the ONC and the 21st Century Cures Act and we want to make sure we are investing our time and energy in the way that would be most valuable.

David McCallie – Cerner – ISP Task Force Member

They didn't give us a directive. Apparently.

Kensaku Kawamoto – University of Utah – Co-Chair

Not yet. We're still waiting.

David McCallie – Cerner – ISP Task Force Member

I could see it either way. Diving into a well-studied space and surfacing what we think is a top idea is certainly something we could do, but we shouldn't waste time if it is well covered by other people. Other groups.

Kensaku Kawamoto – University of Utah – Co-Chair

I think in the prior authorization space in particular, the issue is there is a lot of different efforts or a few different efforts and just having a clear picture of where all of these fit in. I think there is also potential areas where there are some regulatory issues to prevent usage of the latest standards apparently folks want to use in this space. And maybe looking into that was part of the intent of the prior authorization part. Not too expensive, we owe of course, but to sort of make sense of what's going on and help provide recommendations for how to make them work together.

I think we discussed prior authorization and price transparency to some extent, we could discuss more. We haven't talked so much about medication and pharmacy data. So maybe we should discuss that as well. I think the question is what is the scope for medication and pharmacy? In my mind, one of the barriers would be medication dispense that sense data like PDNP data, acknowledging that there are [inaudible] [01:03:16] What do folks think in terms of scope when they think medication and pharmacy data as a potential topic?

Steven Lane – Sutter Health – Co-Chair

Ken, this is Steven. I think I was one of the ones that initially proposed this. One of the things as a clinician that I struggle with is discrete sigs. That some systems support the discrete documentation but then that data gets lost when the medication data is transmitted between EHRs and pharmacy systems and comes back again. And in the absence of discrete sigs, you can't do really detailed decision level support. You can't calculate total doses. The whole issue of morphine equivalency really requires discrete sigs on controlled meds. So that was one issue I thought was important.

Obviously, we went into medications of pharmacies we would have the same discussions around prior authorization and price transparency that we have had with orders and results in a little less so with referrals. What is striking about this, and again I appreciate the task force members who have gone ahead and registered their priorities on the poll we have made available. At the moment medication and pharmacy are ranked most highly by the task force members who have voted so I would be interested in hearing from folks like David, Sasha, Andy, and others. Ricky, why you listed this is your top priority and what you see is beneficial.

David McCallie – Cerner – ISP Task Force Member

This is David. I made my rankings based on what I consider to be the urgency of the domain rather than taking into account whether there was activity underway or not in absence of a clarifying statement from Steve Posnack as to how that he wants the group to work. The medication data, the PD MP issues are a high priority. I think something like a discrete sig is a decade old debate. It is important 1.) whether we can add value or not is an open question, but it is important and that is why I ranked it high. If you want to go into unexplored space, I would rank mine differently I would think. Social determinants and some of the other topics may be higher.

Steven Lane – Sutter Health – Co-Chair

I think the best we can suggest for the task force members at this point, I would say what are you most interested in investing your mental energy is then? Where do you think you could add the most value would be my suggestion? If we all approach this in that way, then we can look to the ONC for guidance and make a final selection.

Victor Lee – Clinical Architecture – ISP Task Force Member

One thing about this particular area that is interesting, currently consumers can get their medication data from their providers, but there is no current requirement for pharmacies, for example, to make data available via API directly to consumers. That is something I think could be extremely valuable especially when it comes to dispensing data, as you noted. which could be valuable for medication compliance.

Andrew Truscott – Accenture – ISP Task Force Member

But I was answering mine, I was thinking pretty much the same as David. There might not be an obligation although we can wait and see what comes out in the two rules which are currently waiting to be released and after the shutdown maybe we will see those. All of the retail pharmacies are – do medication dispense information out to patients. Whether that is CVS or Walmart, etc. Given Steve Posneck’s guidance, I would say maybe we should be looking at something like evidence-based disease further is that such a substantial amount of literature and work being done so far. But certainly not as far as labs and meds. That is just a thought.

Kensaku Kawamoto – University of Utah – Co-Chair

Okay. Just a note, we are showing here folks the votes so far. This went out to the task force members as an email earlier. A few folks on the call don’t have votes on it. The idea here is to rank one, two three, and we assigned five points for one, and three points for two, and one point for three. If you haven't voted, please do so or let us know how you would like us to assign your priorities. If you have and based on discussion you want update things, please feel free do that as well. What we want to do is use this as a mechanism as to where we want to focus next.

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

Was this an email? I don’t have it.

Kensaku Kawamoto – University of Utah – Co-Chair

I will email it to you right now.

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

Yeah, and Ken, this is Lauren. We have a handful of members who are absent today so maybe we can circle back and display the full results once we have heard from those who are absent.

Kensaku Kawamoto – University of Utah – Co-Chair

Yes, we can do that.

Cynthia Fischer – WaterRev, LLC – ISP Task Force Member

And this is Cynthia, I’ll need that too and I’m going to have to sign off in like ten minutes for another meeting, but I’m happy to do it after the fact.

Kensaku Kawamoto – University of Utah – Co-Chair

I am emailing you both right now. Okay. Right now, looks like medication pharmacy is clearly top-of-the-line for folks. Others are kind of evenly distributed which makes the decision making a little bit harder. But I think it is clear medication pharmacy is a priority for a lot of folks right now. Steve or others, any thoughts on how to make use of these data points, acknowledging some other data will come in?

Steven Lane – Sutter Health – Co-Chair

I think the best we can do since some folks didn't see the email, is to leave this open for the rest of the week to the task force members and invite people to talk amongst yourselves and we can certainly have some email discussion as needed if people want to reach out to Ken and/or to me to discuss. But we went to encourage all task force members to vote based on the information provided. And then what we will do is we will consult with the ONC, hopefully by next week and come back with a finalized order of, again, we are looking for two or three additional domains we are going to invest our energies into as well as making time to go back and fully clarify and agree on our recommendations for the earlier domains, so. We hope to finalize that today. We struck a chord and we need to look through some of that. With that, our timing is good to shift to public comments if that works for you, Lauren?

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

That works. Operator, can we put up the phone number and open the line for public comment?

Operator

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

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

While we are waiting for folks, I just want to double back to make sure we didn't miss on the roll call. Leslie Lenart? RajRatwani? Scott Weingarden? Cheryl Tourney, or Tina Esposito? I'm just making sure we didn't miss anyone. Okay, and then operator do we have any...?

Kensaku Kawamoto – University of Utah – Co-Chair

Cheryl's on the public comment so she must be on.

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

Oh, thank you. Got it. Okay. Operator anyone in the queue for public comment?

Operator

We have none at this time.

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

Okay. I will hand it back to Ken and Steven for any last remarks.

Steven Lane – Sutter Health – Co-Chair

Thank you, Lauren. Again, we have got some additional time, which is great. We can focus additionally on the prioritization questions. I see a public comment from Cheryl saying she was unable to pull up the poll. I did post the link in the public comments earlier. I can repost that. The link doesn't seem to work well so again we would very much encourage all task force members to register their preferences.

Jack

I just want to ask about the point made earlier on the call, can we set up a separate poll who is actually going to HIMS and a good time to meet up?

Steven Lane – Sutter Health – Co-Chair

Two things there, and I think that was Jack. There was a question that came up in the public comment as to whether we would reschedule the meeting that's during HIMS, I don't think we have seriously considered that. I think we would like to continue to go ahead and meet during HIMS the week on 12th of February. The time for that meeting is set, the question is whether we can arrange a room for that meeting with appropriate audio access for the group. And again, I was sort of hoping between David and Sasha, one of them might be able to offer a conference room within their vendor space, but we will see what comes of that. In terms of additional meet up, is that what you are suggesting Jack more of a...?

Jack

Like a meet and greet?

Steven Lane – Sutter Health – Co-Chair

Just the meeting, okay. Very good. Yeah. Go ahead, David.

David McCallie – Cerner – ISP Task Force Member

I'm wondering how many people might be meeting in person in terms of room sizing, is it a dozen of it, is it ten? Any sense? Me, Sasha, Ken, Stephen, Andy, that's five.

Andrew Truscott – Accenture – ISP Task Force Member

I'll be there.

Anil Jain – IBM Watson Health – ISP Task Force Member

This is Anil, I will be there.

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

This is Clem, I will not be there.

Jack

This is Jack, I will be there.

David McCallie – Cerner – ISP Task Force Member

Seven.

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

Terry, I'll be there.

David McCallie – Cerner – ISP Task Force Member

Eight.

Ricky Bloomfield – Apple – ISP Task Force Member

This is Ricky, I will be there.

Victor Lee – Clinical Architecture – ISP Task Force Member

This is Victor, is just for the regular meeting, or reoccurring meeting, or...?

Steven Lane – Sutter Health – Co-Chair

If some of us are in person for the regular meeting, how would the in person with the room need to handle? And it sounds like tenish. I will ask, I have no idea if we have a room that size, but I will ask.

Victor Lee – Clinical Architecture – ISP Task Force Member

Let me just ask. This is Victor, it sounds like we have of people who can meet, I have a conflict so I won't be able to meet so I was going to ask if it makes sense if this would make sense to schedule during HIMS at all, but if we can get a critical mass, I'm all for us meeting.

Steven Lane – Sutter Health – Co-Chair

It sounds like we have got a lot of folks that said they would be there, and no one has expressed an unwillingness to meet.

Victor Lee – Clinical Architecture – ISP Task Force Member

I have a willingness, to meet, I just can't.

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

That is my situation, too. This is Clem.

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

This is Ed, I won't be able to join HIMS.

Steven Lane – Sutter Health – Co-Chair

We are starting to a significant number of voices who said they will not be able to meet on the 12th. It sounds like perhaps we should consider rescheduling that. One thing that became very clear earlier in the call is we are going to need additional time to work together to get through the work at hand. One approach would be to instead of meeting on the 12th, to try to two meetings in February, perhaps on the fifth and the 19th, to look at spending additional time working through the recommended changes to our earlier recommendations. Off the top, does anyone especially from the ONC objected that approach, kind of accelerating the frequency of our meetings to make sure that we can both finalize our work from last year and continue to move forward?

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

No objections from the ONC site. I just want to make sure availability across the task force is amenable to that.

Steven Lane – Sutter Health – Co-Chair

I'm going to suggest, and we already have some task force co-chair meetings scheduled for the fifth and the 19th, that perhaps we skip the 12th because of the HIMS concerns that have been raised and instead try to schedule two meetings at an every other week interval going forward and then we would come back next time and pick up our discussion of the 2018 work product finalization, and then hopefully by the latter part of February, be ready to move on with our next domain. Any objection to that?

Victor Lee – Clinical Architecture – ISP Task Force Member

In that case, I would suggest a meetup.

Steven Lane – Sutter Health – Co-Chair

I like that, something more social, I think that is a good idea to meet people face-to-face. and we could potentially just stick with the same time since some of us have already carved that out of our HIMS schedules. I suspect Don and Steve and others will be there so we might be able to engage some of ONC those folks as well. Okay, I'm hearing no objections. I think the proposal is we will schedule task force meetings for February 5 and 19. Virtual meetings like this one, and on 12th February for those who can meet in person. We will look to the 10:00 a.m. Eastern time to schedule a meetup and, Lauren, we can work with ONC to see if you can provide a space or to look to one of the vendors to help us with that.

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

Steve, this is Terry, that is in lieu of the February 26th meeting or in addition?

Steven Lane – Sutter Health – Co-Chair

No, we are talking about now meeting on the fifth online. On the 12th in person for a meetup, not a formal meeting, and then on the 19th again online. But what you're saying is we already have a meeting gets old on the 26th. Why don't we leave the 26th on the calendar since we have already got that? We can make the 19th tentative. We will see how far we get on the fifth and whether we want to meet on the 19th as well, we can determine that after our meeting on the fifth. How's that Terry?

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

It's a lot of meetings but we have a lot of work we want to do and I'm certainly willing to meet if others are.

Steven Lane – Sutter Health – Co-Chair

Hearing no objections, let's plan for that.

Kensaku Kawamoto – University of Utah – Co-Chair

Just is a logistical note, the poll we created was edited by anyone. We have updated to edit by login so folks have voted and don't want to change it, we're just going to go ahead and send an invite to the emails that folks have registered it will just take one more step, but that will be forthcoming shortly.

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

This is Lauren, one last additional note, I know there was a question about the draft recommendations that we were live editing earlier. Those will be made available public at one of our future task force meetings so those will be posted on eventually. We have five minutes, and the other last-minute comments or questions or anything from the co-chairs?

Steven Lane – Sutter Health – Co-Chair

Since we do have a few minutes, if anybody else wanted to raise any questions about the five domains we are discussing, medication and pharmacy, evidenced-based disease management, social determinants, prior authorization, and price transparency, sorry, I read them in a different order, this would be a fine time to address any questions there.

David McCallie – Cerner – ISP Task Force Member

This is David. I just wanted to say on Ken's proposal around the evidence-based disease management, it seemed to me there were a couple of concerns he talked about. One is what clinical data should be captured for good care, I would suspect that is probably not our interest or our focus. The second is how do you capture structured data that could be used to drive evidence-based medicine, and that would be of how to use fire to capture the data and how to integrate it into the workflow. And I think that could be a topic of interest because there isn't a consistent way of doing structured data today. I think everybody interprets the point panels and everything else somewhat differently. Some people use fire questionnaires, some people use nested observations. A friendly amendment to Ken's proposal.

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

Could I just add to that too. It is true there are different ways to put it in structures, but that is not as important as the fact of choosing different questions. Somehow, we have got to face up to the fact to big industry. There are lots of people developing the forms and we have got to somehow get them to converge.

David McCallie – Cerner – ISP Task Force Member

Clem, I was suggesting decoupling those so the decision about what data to capture is a complicated space in and of itself but how to do it once you've settled on the data is open for health IT to deal with.

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

I'm on the questionnaire task force and a questionnaire panel is just sort of how you cross your eyes. I think it is a matter of what we are going to layout. We need an example set and talk about how we're going to put them out because otherwise we just go in circles.

David McCallie – Cerner – ISP Task Force Member

An abstract way to do structures that is deeper and better than a silly questionnaire resource. I think that is a pressing need that hasn't been solved yet.

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

I'd like to argue about whether that is silly, but that's another story.

David McCallie – Cerner – ISP Task Force Member

A pet peeve. I think that is an area where we obviously have some discussion if we wanted to take that on. There are others.

Steven Lane – Sutter Health – Co-Chair

Thank you both. Again, what we are doing in the background, we are retooling the pole to make sure only the task force members have the ability to edit their entries and we will be sure to get the poll sent back out to everybody with today's meeting materials. We strongly encourage all task force

members to register their preference as to how you feel your time and energies can be best invested going forward at our next meeting. Which is now going to be on the 5th of February in two weeks. We are going to go back and continue our discussion on the results and recommendations and then hopefully move on to the recommendations regarding the referrals and care coordination. If we don't get through that on the 15th, or excuse me, on the fifth, we will continue that discussion probably on the 19th and plan to start our next domain work on 26 February. Having said that, we are at the time. Thank you, everyone, both the task force members and the public for your active participation. We appreciate it and we will hopefully see some of you at HIMMS.

David McCallie – Cerner – ISP Task Force Member

Sounds good.

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

Thanks, everyone.