



Health IT for the Care Continuum Task Force (HITCC)

Transcript
March 22, 2019
Virtual Meeting

Members/Speakers

Name	Organization	Role
Carolyn Petersen	Individual	Chair
Chris Lehmann	Vanderbilt University Medical Center	Chair
Aaron Miri	University of Texas Austin	Member
Steve Waldren	American Academy of Family Physicians	Member
Susan Kressly	Kressly Pediatrics	Member
Chip Hart	PCC	Member
Lauren Richie	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator for Health Information Technology	HITAC Back Up/Support
Stephanie Lee - Office of the National Coordinator - Staff Lead Lanie Lee	Office of the National Coordinator for Health Information Technology	Staff Lead
Samantha Meklir	Office of the National Coordinator for Health Information Technology	SME
Zoe Barber	Office of the National Coordinator for Health Information Technology	Back Up/ Support
Al Taylor	Office of the National Coordinator for Health Information Technology	SME

Operator

All lines are bridged.

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

Good morning everyone. Welcome to the Health IT for the Care Continuum Task Force under the HITAC. We will call the meeting to order starting with roll call. Carolyn Peterson?

Carolyn Petersen - Individual - Co-Chair

Good morning.

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

Chris Lehmann?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Good morning.

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

Aaron Miri? Not yet. Steve Waldren? Chip Hart? Sue Kressly?

Susan Kressly - Kressly Pediatrics - Public Member

Present.

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

Okay. Hopefully, the others will join us soon.

Chip Hart - PCC- Public Member

Sorry, this is Chip. I'm here. Sorry, I was on mute.

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

Okay, good morning. Okay, I'll turn it over to our co-chairs Chris and Carolyn. Thank you.

Carolyn Petersen - Individual - Co-Chair

Good morning. It is great to see everyone again bright and early this Friday morning. I hope you had a good week and are ready to get started on the next segment of our review. Today we will be trying to get through recommendations seven through 10 to finish up that part of our work. And I will pass the mic on to Chris for any comments he has.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes, good morning. So, when I was getting ready to get on this phone call, I was thinking this is turning into a full-time job as we had an opportunity to present your work from the last two phone calls to the larger HITAC group this week. And so, Carolyn will give us a little bit of a flavor of how that went, and so, but just to sum my impression up, we were able to present your hard work on the last two calls,

and I think it was perceived rather well. So – but that is just my impression on the phone. So, I will give it back to Carolyn, who was in the room.

Carolyn Petersen - Individual - Co-Chair

Yes, thanks, Chris. So, as we – on Tuesday, the day when we had our meeting related to the NPR and work that the task force is doing across all the different initiatives that are a part of the NPRM, Chris and I had about 45 minutes to present to the full HITAC. So, we reviewed the charge and the scope of our work and indicated that we had a tentative consensus about recommendations seven to 10, but that we would be reporting back in more detail on that in the future, which will be at the April 10 meeting of HITAC. And then at that point, Chris reviewed our recommendations and our discussions related to the first six recommendations. After that, we had a brief discussion with members. The primary consideration being how this is going to be different from other specialty EHR or other special situation reviews. And we – just the fact that actually, it may have quite a number of similarities with other kinds of EHR's that relate to special situations, like dental EHRs for example. And indicated that our process may serve as a model for what other committees will wish to do in the future as they look at other special situations. But on the whole, we didn't have anything that I would characterize as push back per se. It was really more informational and questions and getting the group up to speed in terms of what we are doing and the details of our work to date. So, I think Chris and I both felt quite good about it when it was over and the indications, we have from our colleagues at ONC were positive as well. So, I think we are on the right track, and things are looking really good for us. Did you have any thoughts Chris from your discussion with the members?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

No, I think you summed up quite nicely. I had a little bit that day outside discussion with other stakeholders in pediatric safety convened by the Pew Trust and there was a general consensus that these recommendations were generally in the right ballpark.

Carolyn Petersen - Individual - Co-Chair

Good, good. That's really good to hear. So, I think if, does anyone have any follow-up questions or discussion about our presentation at HITAC this week? No? Well, seeing that we don't have anything to take care of today regarding the first six recommendations, I will pass the mic to Chris to get started with recommendation number seven.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

All right. Let's get to work. We have four more recommendations to go. The next one is recommendation seven, transferable access authority. The description is that the system shall provide a mechanism to enable access control that allows a transferable access authority. For example, address change in the guardian, a child reaching the age of maturity, etc. So, let me stop here and see if there are any comments, any concerns about implementing this. My general perception of this is this is for the most part already implemented in existing EHR's. But let me pause here and see if anybody disagrees.

Susan Kressly - Kressly Pediatrics - Public Member

This is Sue. I am stuck with really trying to understand the problem this is trying to solve. Can you give me some more color around what the intent of this is that we are trying to do? If it – when a, you know, the parent is allowed to be the healthcare representative for a child until the age of x, in which case the child becomes the keeper of their information? Or the source of truth, or what are we trying to do here?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

So, I haven't – I didn't go back to the original pediatric EHR format, but if I recall correctly, this is the issue about the emancipated minor. The change of custody, going into foster care. We already have the issue that we wanted to have the ability to identify these – all the people that are involved in a child's care and speaking of healthcare. But this addresses the authority and the mechanisms to provide consent and access to the information. So, I think that is what it addresses.

Samantha Meklir - Office of the National Coordinator - SME

So, Chris, this is Sam. I just wanted to interject, if it's okay. In looking over some of the discussion on this from the listening session, I do recall there were discussions to rename the priority to include the concepts expressed in priority three, specifically identifying all guardians, caregivers, siblings, and caseworkers and their related roles and access rights, including the emancipation of the patient. So, I think Sue, to your question regarding confusion, I recall some of it may have stemmed from the delineation in the title of the recommendation itself if that is at all helpful. I just want to relay that historical information.

Susan Kressly - Kressly Pediatrics - Public Member

Very helpful, thank you.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes. Thank you, Sam. I was just pulling my slides back up from that listening session and that is exactly what I had in mind as well.

Susan Kressly - Kressly Pediatrics - Public Member

I noticed somewhere that somebody wrote about current standards somewhere to indicate consent or authority or medical decision-making. And I'm blanking on where I saw that. If somebody – because are we really just saying that we want to hook what we talked about before about multiple contacts and then be able, the EHR should be able to use, you know, already known nomenclature to tag those. Mark those contacts in regard to their ability to consent or see information in the care of the child. Is that what we are talking about?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I'm sorry, can you ask that again Sue? I missed your point.

Susan Kressly - Kressly Pediatrics - Public Member

Yeah, no, so, I think somewhere I saw and I, it was maybe on somebody's comments but there already exists this standard, I don't know if it's HL-7 or something else, about authority. About care authority. Or am I making this up and it doesn't exist?

Al Taylor - Office of the National Coordinator - SME

This is Al. There was a standard, and it may have been my comment, although it's not, so it's identifying the person in this, whether the person has legal authority to access records for its part of the care team or it's just another relative. There are standards around there that can be used to designate who a person is. The ability to, you know, assign that person as authorized access whether it is for accessing records, making decisions, or accessing the portal, as the purview download and transmit portal, those are separate than who the person is that's being granted that access. Does that sound like something that you were thinking about?

Susan Kressly - Kressly Pediatrics - Public Member

Yes, well, I'm just trying to figure out how you operationalize this if we are asking EHR's to do it, right? We don't really want everybody to make this up their own way, because then will we transfer records know that goes with it. And so, what I was looking for is that standard already defined, or do we need to request that there is a better standard to determine when we're sending data across the care continuum of this means this is, has medical decision-making authority, this means has view authority. You know, are those standards exist and if not, can we point the HR vendors to them? And if they don't, how do we accomplish it without that?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes, and I think that, and Sue, you brought up some very important distinctions. So, the way I look at it, and how I, you know, given the case for example of a child that is in my newborn intensive care unit that has biological parents who want to give this child up and there is already a future adoptive family who is involved. You have the issue of who can obtain information about the child, who can learn about the medical information that we have collected, who can consent to procedures, who can be actually bringing this child to let's say to a follow-up appointment. So, even if I am not consented yet to be the person who gives the permission for surgery, it still might be, I still might be entitled to bring this child for a regular child check up to the pediatrician. So, there is some nuance to this, and it would be really helpful if at a later call we could dig into that a little bit. Because making sure that whatever we choose for that is the right set of standards is going to be critical.

Susan Kressly - Kressly Pediatrics - Public Member

And EHR vendors do not want to get in the business of trying to keep up with state regulations. I think that what we are asking is that the EHR empower the user to use what they know about state regulations to tag certain roles, so that there is appropriate ability to make care decisions, view information, and ideally that information is tagged in a way that every EHR record recognizes so it goes from one place to another place that care continuum and access is understood across all domains. Not when making this up in silos.

Access authority based on every state and territory is really a key point. To say everybody who is a parent has access or everybody who is a parent of a 16-year-old or older doesn't have access, those kinds of automated rules are going to be impossible to implement. But I'm just saying, this person A has access, and person A is a grandparent as opposed to – then it changes to now this grandparent no longer has access because a parent does. Just to say who the relationship and the responsible party

and those are the terms that are used in those relationship standards that I had mentioned in the past. I think to be able to capture the relationship and responsibility into whomever you grant access based on local laws. I think that would be very, I think that is a good thing to have. I don't know that we have any standards around the basis of the authority. The basis of the authority to access. But who the person is and what kind of a relationship they are, I think would be, I think would be key to capture, I think?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

And we have that already in, I think, in requirement three. But I think what I am starting to hear in this is, that this needs actually, this nomenclature needs to be developed. Because the – ultimately the rights that can be bestowed on you are the same, they just might be differently regulated by different states and territories. But I think there is a great need to have a standard nomenclature that we can use and apply them based on state laws. And just to point out, because this is a – for pediatricians, this can be a challenging, a gnarly problem to deal with especially in a divorce situation where one party claims the other has no access rights or etc. So, this is a tough thing to manage. At least you want to have the nomenclature right.

Chip Hart - PCC- Public Member

Yes, can I add two cents here, just one second? I think everyone is on board with the philosophy we want to accomplish here, but this one is the one that I wondered about removing only because it is so broad and so vague right now with no great landing place or architecture that we can frame anything around especially when the best we can say right now is so that the physician can follow state laws, which we all think is a disaster, because we don't even know what that means. And you know, some earlier versions of child model format and certainly this was true all the way back to CCH IT. We sometimes ran into feature requests like this where it could be resolved by simply a text field. Which is not the intent here, right? We don't want to say, oh, all EHRs are going to have a little box in the corner that describes who has access. The problem is, and Dr. Lehmann, you already gave some examples, there are about 25, I bet we could brainstorm right now 25 or 50 different custody control access examples that are totally contradictory or have a different set of people involved or have – when this talks about needing a mechanism for access now suddenly need a new button or a new switch to control it. I think this is really broad and really scary and like Sue, I will say it less politely than Sue, when you have broad and scary guidelines the EHR vendors make really bad design choices, you know, all the time. And that's – the problem I have with this one is I don't think we are quite yet even accurately describing what it is the EHR can do and should do. That is all. I still, I think this is a vitally important item. I don't even think our society knows what to do in many of these cases. You pointed out in these messy divorce cases the computer can't solve the problem.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

That's right. But at least, the computer should be able to document what the condition is. Right?

Chip Hart - PCC- Public Member

Correct, but how do you do that without a text field because, as Sue pointed out, we don't have a standard to point to that I'm aware of.

Susan Kressly - Kressly Pediatrics - Public Member

So, let me think outside the box here and I think there are two things. I would love there to be a standards nomenclature that we all agree on at some point that says this means I have medical decision-making authority on behalf of the patient. This means I have an emergency only privilege. This means I can view versus whatever. I don't know what those are, we don't – I don't think they exist, but I think they should. But in the short term to do something and start the conversation, what I would love to see here is that we narrow this focus and say that the end user has the ability to make those decisions. The end user can mark each of those people with a specific privilege, and maybe, we are going to make this up in weird places but at least we can start people thinking about it until we can come up with a standard nomenclature to overlay that. But in many places it is the health system that is making the decision about the 13-year-old it is a special needs 13-year-old and the bottom line is the end user should be able to say yes this mother just died, this grandmother has emergency and switch it – the control needs to be at the end user in my opinion and get the EHR out of the business and I am not sure that exists in every EHR.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I hear you. And I'm thinking that maybe we can come up with a limited nomenclature, at least for the different rights that we have. Access to information, ability to add information, ability to make medical decisions, ability to take the child to the pediatrician. So, those kinds of things I think we should be able to come up with something that at least would standardize this. So, maybe there's – we'll do some huddling with the ONC staff later and see what kind of resources there would be available to either look into whether somebody has already described this, or whether we could put some elbow grease into it and at least come up with a set of standards for that.

Susan Kressly - Kressly Pediatrics - Public Member

And I would do it keeping in mind that this happens at the other end of life, right? So, let's not build this for kids, let's build for anyone who needs a healthcare proxy. Whether it's an adult who is not capable of making their own decisions or, and a geriatric patient. But let's make it broad enough that it makes sense.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

And we'll call it a special beginnings and endings standard.

Steve Waldren - American Academy of Family Physicians - Public Member

Bad joke, bad joke.

Chip Hart - PCC- Public Member

I was like wow, would they let that happen? I didn't think you were joking.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes, I was joking.

Steve Waldren - American Academy of Family Physicians - Public Member

One of the standards if it is not listed on how to represent the security assertion markup language or SAML. I don't know if that is listed.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

And what was that? Assertion?

Steve Waldren - American Academy of Family Physicians - Public Member

It's the security assertion markup language or SAML. So, it's a way to assert what you have access to and what the decision is to make that access. So, it's just a standard for representation. It does not solve our problem of you know, what's the decision and what's the resource. But there is a standard way to represent those authorizations.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Would be nice to look at it and see if we can at least use that standard to build the things that we need. That is a good suggestion. Thank you, Steven.

Steve Waldren - American Academy of Family Physicians - Public Member

But I think it is a good idea, we may need to distinguish between access, the access standards, and the legal decision-making standards and whether or not, I think there's a question as to whether or not we can automate the legal decision-making authorities as well as the record access authorities. I think those may be two separate things.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Well, actually, there is a supplement to this requirement that is the system shall provide the ability to record the patient's emancipated minor status. And that kind of implies that we really hear here two things. We do have the access and we do have the authority to consent issue as well. So, I think this recommendation was to include both of them, and that's why we have that emancipated minor strapped onto that. All right. Clearly, we're not ready on this recommendation for prime time. I think we need to do some more research and some discussion about this, whether we can create ad hoc limited standard that would be useful for this. I suggest unless there is any more discussion around this that we move on to the next recommendation.

Chip Hart - PCC- Public Member

Can I just add one thing? Sue, this would be a really great thing to bring back to **[inaudible] [00:23:47]**. Because if the Academy, even without a technical standard, just had a best practices standard about how to track this information we would at least have a roadmap for good design or good workflow. That – it does not even exist right now. And so, I hope that makes sense.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Led us now to best practice paper, you are absolutely right, Chip.

Susan Kressly - Kressly Pediatrics - Public Member

Yes. Well, this could tag along on the privacy work that the subgroup is doing. It is all part of the same thing for figuring out how to do this. It's – you have to figure out how to tag information. They have to

figure out how to let people get access to it. So, it is just broadening the scope from the inside the healthcare team to whatever roles other people play in the life of the child. So, I'm taking notes.

Samantha Meklir - Office of the National Coordinator - SME

Chip, this is Sam. Would you – others are likely more familiar, so forgive my ignorance here, but would you be able to share an example of that type of best practices documentation that you were referring to as it may be, there may be an existing example to look at?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I don't think there is one. But the AP does write guidelines and best practices papers where they recommend that pediatricians do things in a certain way. That is usually limited to how to treat a specific disease. I, you know, just helped write a best practice guideline for iron deficiency anemia. But it can be also focused on things like interacting with an EHR. I think – I just made a note. I think this – we'll have a call later today with a group that Chip was referencing, [inaudible] [00:25:48] and I will ask them if there is any appetite to actually work on that.

Al Taylor - Office of the National Coordinator - SME

This is Al Taylor. We have some private security folks here at ONC who can perhaps shed some light on what those terminology and process standards might be from the technical side.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Excellent. Good. All right. Any last words on recommendation seven? If not, then we will move on to eight. Title of that is associate maternal health information and demographics with newborns. So, this is a tricky one. This is one that is primarily targeted at the inpatient environment. The system shall provide the ability to associate identifying parent or guardian demographic information such as relationship to the child, street address, telephone number or email address for each individual child. When we looked at that in the EHR format, I remember that this also kind of implied that there is a mother-baby link in the EHR. So, a number of vendors already provide that, provide inpatient EHR. It is quite simple to go from the child records to the maternal records and import significant information that could affect the health of a child such as group B strep status. Or information about the pregnancy that would be relevant to the child's care. And so, I'm just – to me, this is less relevant to outpatient settings and more relevant to inpatient settings, but I will just pause here and see how others perceive this.

Chip Hart - PCC- Public Member

Yes, this only works for an EHR that has a maternal clinical record in it already. I mean, I don't know if Sue ever runs into this, but this is something PCC never deals with. Because the patients are the fundamental record holders. Not the record holders but that it's – our databases are filled patient records and we are not really holding maternal clinical data, except as it is recorded in the patient record. I think if you wanted to expand this, I don't know if this is a good idea or not but if you wanted to bring this into the ambulatory space you could talk about an ambulatory EHR receiving a maternal clinical record and absorbing it into the child clinical record.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

That's an excellent suggestion. But let me ask Stephanie Lee - Office of the National Coordinator - Staff Lead. Stephanie Lee - Office of the National Coordinator - Staff Lead, as a family practitioner you take care of whole families. Grandparents to the grandchild. Have you encountered EHR's that actually integrate family relationships well? For example, if you take a family history on one child that propagates that information to other children in the family?

Steve Waldren - American Academy of Family Physicians - Public Member

It is kind of hit or miss. Some of it does where you can replicate it across, but most are all set up as kind of – as just was discussed and you have the individual records for each individual patient. So, and the only other thing I was thinking about from the ambulatory standpoint is those instances where the burden's not at a hospital, but I think, as we're going back to the kind of the core of what is the minimum necessary for pediatric, I don't think we have to worry too much about that case. I just wonder from an ambulatory standpoint, though, if it is just making sure that there is a set of fields for maternal data that is relevant for the patient. For the child.

Susan Kressly - Kressly Pediatrics - Public Member

So, Steve, you just read my mind. I think the problem we are trying to solve here is that there is certain perinatal information that is important for the care of infants that is directly related to the mother's history. So, saying something like either providing a link to, in the case of an inpatient set only, or the ability to record permanent perinatal or maternal information that is obviously not the child's information, right? So, how do you put it inside the EHR that it is like, you don't make a mistake and think it's the kid's herpes strep status, it's obvious it's the maternal's history as discrete information, I think gets to the spirit of what we're talking about. And that is not so prescriptive that people can't do it in a certain way. Now, I would love to make it so it is not just a blob text field somewhere but I don't know that we have the ability to say which elements should be discrete data or not, or if we just say some of which needs to be discrete data, I want to refer to what is possible versus what is the ideal?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Well, actually –

Steve Waldren - American Academy of Family Physicians - Public Member

Maybe just one quick, I'm sorry Chris, one quick friendly amendment to that. I think the inpatient EHR needs to be able to have that stored in its record for the kiddo because a lot of times the ambulatory is only going to be able to request, or may just request the kids record from the hospital if it's of a different pediatrician than the one that was taking care of them while they were at the hospital.

Susan Kressly - Kressly Pediatrics - Public Member

Yes, so linked and pulled into a report about the intent, right? Because in some hospitals like mine, they don't even use the same EHR. I've got to go between two screens.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I think there is, Chip said something earlier that I very much liked. I liked his suggestion that this information should be available in a format that can be exported and digested by a pediatric EHR. That is the thing that I really liked because that makes a lot of sense. And that then allows us also to, if you

have a standard format in which is transmitted, you have a set of elements that will be granular and that will be, can be used for decision-support downstream if you need it to and that really opens up, and I'm just going to open up another can of worms. That also then leads me to think is, should the, and I know a lot of pediatricians who will say emphatically yes to my question now. Should the EHR also be able to digest the results of the state screening of newborns? And I feel very strongly about it. But I'm just going to put this to the group. The challenge there is that state screens vary from state to state and territory to territory and the types of tests for certain diseases vary as well. So, there's no standardization there. So, one state screen might include 26 items, another one 35 and they might choose different testing methodologies for an item that both test on. But I think this is, this is really pertinent information that has a significant impact on the well-being of children for diseases that actually can be acted upon. That is the beauty of these state screens. Those tests are for diseases we can actually do something before the damage is done. So, I'm just going to stop here and see how others feel about state screens.

Chip Hart - PCC- Public Member

Well, let me add to that. So, if I follow along properly one of the implications is that at every hospital around the country that sees newborns, that an ambulatory pediatrician is asking for files from, data from, they are going to receive potentially different levels of maternal information and state screening tools. One of the points we want to make is, so, great, you are now part of care quality, someone sends over the CCDA with the actual results in it, or some other form, it doesn't matter. What we want is the ambulatory pediatric tool to be able to receive as much valid data as possible, and not throw out that important maternal data, those important screening results. Correct?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I agree.

Chip Hart - PCC- Public Member

And so, it strikes me, like I'm adding a corollary to your comment, which I think may be a better or stronger way of focusing very specifically on one button transfer of maternal information within the same EHR. Because that's not – to me that doesn't even feel like a necessarily pediatric thing.

Al Taylor - Office of the National Coordinator - SME

This is Al from ONC. We actually had done, for the question, the question of transfer of maternal data, about a year or two ago, we had done an analysis of the state of the CCDA and its ability to really just hold information from a different patient. In this particular case, it would be maternal data in the pediatric lab section. Lab results section. There really is no current capability for a CCDA to hold the model of the lab results section, there is not the ability to hold, there is not a section called maternal lab data or lab data or the lab data does not have the metadata of another person as a source. That would need to be, if we're talking just about CCDA, it would have to be, that would have to be modified and then there would have to be a way to import the maternal data before you compile the CCDA. There is also nowhere in the data model where it – it's sort of a, it's a provenance question about does this, what the source of the data is a different patient? It is a tricky thing and the lab data model, other results sections don't have that capability right now to say, this is a lab result but not from this patient.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I am a little perplexed. Do we never ever – I guess we, again there are other diseases where you get, for example, HLA subtypes of relatives to identify whether they're potential donors. So, that concept exists in medicine, where you have lab data in a patient's chart that is critical, but it comes from somebody else.

Chip Hart - PCC- Public Member

Al, the implication of what you said, and I should have thought through what I was saying better earlier. I'm sorry. Is that the only circumstance in which this feature is needed is when you are talking about when a patient and a child and a mother exist in the same EHR. Because as soon as you leave, you could be from hospital to hospital. Not even an inpatient thing. You'd be just an outpatient, an ambulatory thing. From hospital A to hospital B, patient transfers, there's – if there's no place within the record to transfer maternal data with the child data, then the only data that is going to come over is the data that is already in the child record as being the child's data. So, I had always, I was trying to broaden this, I guess, to say, boy, this would be really effective as a system to system conversation but this is literally – what it really means is on one database within one system, within one healthcare entity we want to associate the maternity, the maternal information with the child information which seems very limited in scope to me.

Al Taylor - Office of the National Coordinator - SME

Well, I think that the capability exists, it just doesn't come back as – just like family health history is more of a – it's almost like a textual, is a text, it is text information. Family history is not the same thing as lab results in format. And so, a pediatric record could contain that family health history of whatever but usually, that is not granular enough to represent GDS status or HLA typing or those kinds of things. The transfer from hospital to hospital or hospital to outpatient, that still happens but the records are not integrated. You can't – like the pediatric – the ambulatory EHR would not be able to ingest maternally. They would be able to ingest pediatric data that has a maternal history in it.

Chip Hart - PCC- Public Member

Right. Yes, that's exactly right. And I think I agree with you wholly. And so, the only way that – the only way that this would affect an EHR designer or developer would be when you are looking for maternal information that exists within your existing database now. You have a maternal record sitting next to a patient record. It is not an example of we got maternal data from somewhere and we want to pull it into this patient record. It's literally – it can only be because a lot of these mechanisms don't work, it can only be data that is, I am not articulating this well. But if you've got a patient record, and there is maternal data in has been added, let's just say manually for right now. Everyone presumes that data can be sent and received. That's not always true, but let's just presume that's the case. This is trying to say that you can associate information when, because that is not already done that way. It is done differently. Sue's system and PCC system, we have been doing this for 30 years. It is such an odd request for us. I'm trying to think of when we would – I would ever even apply this. I hope that makes sense.

Al Taylor - Office of the National Coordinator - SME

We say we have been doing this, which are you talking about?

Chip Hart - PCC- Public Member

Provide the ability to associate identifying parent or guardian demographic information, you know? I'm going straight from the fundamental –

Al Taylor - Office of the National Coordinator - SME

Not necessarily lab data?

Chip Hart - PCC- Public Member

No.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes, but we are talking more here. We are talking about maternal medical information that is actually part of the maternal record. That is really –

Chip Hart - PCC- Public Member

Right, but, and so, here's the thing. As a rule, just using PCC as an example, so it's a very, very narrow scope. PCC doesn't record any clinical information for the mothers as a rule. Any information that is applicable to the patient just gets added to the patient, okay? And so, we could have mother's blood type okay? And I'm just making this up. And that is now part of the patient record. And what – I was trying to read this originally. How does apply to us in the ambulatory space? And that was me saying, oh if someone pointed out a maternal record that existed somewhere else and said apply the appropriate clinical data from this maternal record to this child record, that is how I was looking at it. But it seems to me, this is always a matter, I was trying to make is always a matter of data coming from outside the system applying to a patient record on the system I am in but really this is about within your single epic hospital implementation connecting to patient records and sharing the appropriate data.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes, or transmitting the data. So that can be if you have recorded that the history of the family history of one sibling that you could share that with the other three kids that are in the office at the same time.

Susan Kressly - Kressly Pediatrics - Public Member

So, Chris, that's me is different. And the scope of this I believe is discrete capturing of maternal information, so it is obvious that it's maternal information and not the patient information. I already have discrete fields. Mother's blood type, mother's HIV status, all that sort of stuff. All of that stuff as discrete fields. It has to be hand entered because there is no way to map that data because there is no standard for it, which I think eventually would be awesome. I'm not even sure that every ambulatory EHR has the ability to record maternal information that is relevant to the kid as discrete information and if we are going to start somewhere, we start somewhere. And I will tell you that the whole family history thing is a bigger conversation. OP clearly does this. We have what we call a social family, that's people who share the same address, a genetic family, that's like, and that can be, we even have the

sperm donor mother as the genetic family and we can link kids and we do have, if you recorded in one sibling's chart if they share the same genetic parents, it is copied across all the other sibling's charts. So, we do that. But we're – again, this is, you know, it's our core business and it is our value proposition. But I think that is a bigger chew, and different than just taking the ability to record import. Now, I could go one step further and say when the kid comes of age how much of that maternal data are they allowed to see?

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes, that is a big one.

Susan Kressly - Kressly Pediatrics - Public Member

You know, if the mother was treated for an STI in her third trimester or herpes or whatever, is the 17-year-old allowed to see that about their mother when they are older? That to me, having it be able to record it as discrete data but segregated in the release of information for privacy purposes is – would be an ultimate awesome goal.

Steve Waldren - American Academy of Family Physicians - Public Member

I wanted to interject something about my experience with certain EHRs. The ones that, in particular, the one, I don't know that much, I don't know about Epic and how they map maternal to newborn data. I am assuming that they do. However, that is linked. The EHR that I used to use which is in place in all the DoD inpatient facilities around the world is that when a baby is born in a hospital it is on the same system. When a baby is born in a hospital, it creates a newborn record which imports what we have designated to be the pertinent maternal data including gestational age and labs and all that, and other histories. So, that does happen. At least in one case, probably in more than have an integrated inpatient record. The question is how is that done? What is the data model behind the imported maternal data? Is it a text field? Is it Low Inc. data? Is it – what is it? I don't know the answer to that question, and it probably, because there is no defined standard yet for how that happens it probably is different in every EHR that does it. I am just going out on a limb. But it does happen that import maternal data does happen for inpatient records that does OB in newborns. It's just, there is no standard behind it right now, I don't think.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

All right, so this turned into a much more difficult discussion than I had hoped for. But it was actually a very good one. I think what I have heard is that there is a desire for some maternal information relevant to the health of the child as well as potentially the newborn screen to be able to be sent and digested by a pediatric EHR. At this point, there are no good standards that we are aware of how to do this. And there is clearly the need to do further work, but it is a functionality that is important to the well-being and the health of the child. I think we can leave it for the moment here and we will do some more work and see what there is in the form of standards for the state screens and newborn screens and what is there in the form of, you know, the existing transmission of that data. See if anybody has worked on this and found any solutions. Did I sum this up all right?

Al Taylor - Office of the National Coordinator - SME

Chris, this is Al again. I wanted to make a comment on the state screen. I believe that standards exist. Whether or not every state screen has a Low Inc. panel code or not is a separate question. But state screens or labs may be run by a different lab, maybe in a lab that is not required to use Low Inc. but to order a state screen is to me a lab test that can be represented in Low Inc., whether it currently –

Susan Kressly - Kressly Pediatrics - Public Member

I agree.

Steve Waldren - American Academy of Family Physicians - Public Member

You are right on the money there. I agree.

Chip Hart - PCC- Public Member

Al, I also appreciate hearing you pronounce it Low Inc. Because, here we say Low Inc., like Homer Simpson. So, it took me a moment to understand what you were talking about.

Al Taylor - Office of the National Coordinator - SME

I think thank you.

Chip Hart - PCC- Public Member

I was like, oh, that's how you pronounce it. Okay, never mind.

Susan Kressly - Kressly Pediatrics - Public Member

So, there's a bigger issue with the newborn screening I just want to say. I agree that it should be Low Inc. and absorbed in your lab feed however you get it. The problem is that most of those screens go back to the place that did it which is the hospital. And everybody has different ways of figuring out how you get the primary care to follow up personally. Because that is not even always known at the time of discharge. So, there's a logistics issue and I can't query somewhere to say here's my patient born at this hospital, let me have that result. I have to go on a website and print out a list because I am an authorized user in my office and most state screening organizations that are collecting the data are not feeding it back to the PCP. So, it's not just the ability to absorb it. It's like – I'm not even sure it gets to the right people at the right time. It is all going back to the birth hospital or the birth facility that drew it. At least in states that only have one. Now, there's clearly states that have two, and in most of them I do believe because the physician orders them, the PCP orders them, it is coming back to them as a lab result.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Yes. Those are good points, but I think what I said earlier Sue was if somebody were to send you that information you should be able to integrate it into your EHR.

Susan Kressly - Kressly Pediatrics - Public Member

Yes.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

So, let's deal with that aspect that you can digest it, and then we will bug ONC later about making people send it. One step at a time. That's how I would look at it.

Susan Kressly - Kressly Pediatrics - Public Member

That works for me.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

All right. Moving on. Does anybody have any more parting words for this one? This one was actually a head scratcher I have to say. Another case of us recognizing what is important for child health and technology not quite ready for it yet. So, quite interesting. All right, then we have, let me do a check with the ONC staff. Do we have time to tackle the next one?

ONC Staff

Absolutely.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Okay. All right, recommendation nine is the track and complete preventive care opportunities. Now, this is a big one for pediatricians. I am pretty sure it's a big one for family practitioners as well. The description is the system shall generate a list on demand for any children who have missed recommended health supervision visits, preventive opportunities. According to the frequency of visits recorded in bright futures. So, this is very specific. It references an AP product, bright futures, which has a recommendation for screens that children should go through as they reach certain ages. So, age 1, for example, includes hemoglobin to identify children with anemia. There is a whole list of preventive opportunities. They go from screeners to immunizations and other interventions. So, now without being too critical, the bright futures in itself is, you know, and I think Sue and Chip will be able to speak to that, it is challenging to implement in an EHR. But it is clearly the bread-and-butter of pediatricians. And for anybody who deals with children, something that is critical to be able to do within the EHR. So, I'm going to pause and let Sue and Chip tell us how they have managed to do that.

Susan Kressly - Kressly Pediatrics - Public Member

So, let me just say that I applaud you're wanting to put in all of the care plan items in bright futures, but I think that's not where we should go. I think that we should just start with the ability to recall and identify patients who are missing a well-visit period. And I will tell you why. A lot of the HRs can do annual well visits and they can tell you, anybody who's been with 365, the devil is in the periodicity schedule that exists in the first three years of life. Did the child – is the child due or overdue for a two, four, six, nine, 18-month, 12-month? That is where most HER ambulatory EHRs fall short, and that's where kids lose access to care. I would vote for, and I will also tell you that taking care of lots of, talking to a lot of practices evening practices, even the practices think they're all special snowflakes and have reasons why they don't follow bright futures, including sometimes they don't align with the Medicaid regulations in their state. So, I would argue not to do the granularity of what happens at those well visit and create care plans to individual items but just let's start with the ability to identify well visits periodicity based on the bright futures schedule and create a recall for those care gaps including the periodicity for children under three years of age.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

That seems like a reasonable recommendation. I applaud, I have some issues with the decidability of bright futures and the actionable ability of some of those recommendations and they tend to be at a higher age. The lower ages are actually the ones that are better defined.

Chip Hart - PCC- Public Member

Okay, my two cents, I generally agree with Sue. I think that this is a two-pronged demand. When we say track, we want to be able to generate lists. I mean, that's right there from the child model format. You want to be able to generate lists for recall purposes. I also think we want to be able to flag patients or otherwise create an alert and I realize that is opening Pandora's box, but I can tell you because I've done this analysis, 20% to 25% of the kids that walk into the pediatric office every day are overdue for their well visit. And that's awful. The average teen well visits coverage in this country is below 50%. So, I agree with Sue, let's start with something that is really pretty – it's pretty simple and it is in fact – all the other missing preventive care opportunities whether it's screenings or immunizations or anything, those are all based on the kids actually coming in for a good visit. And so, I do agree to start there. I just want to see something that says – we've already got in this list and certainly within other aspects of EHR certification requirements we want some sort of alert or notification when patients fall outside our expected values. I like to see the bright futures well visit schedule considered to be an expected value somehow. And so, this kid has not been in 13 months, or this kid has not had a six-month visit.

Susan Kressly - Kressly Pediatrics - Public Member

So, Chip, I'm going to agree with you, and there are elegant ways to do this. When you're talking about is population management with a recall capability. Show me my list of kids who are overdue, so I can work that list. But also, the ability to alert the user at the point of care when they access the patient record that the patient is overdue for that good visit on the individual patient level so that care gaps can be closed while the patient is in front of you. We do it by showing the date of the last well visit on the chart, and it's in red if the kid is overdue. The date is just red. I mean it doesn't have to be a popup, it can be alerted elegantly in a lot of different systems. But I think that's a really great point, the ability to do population recalls based on bright futures periodicity and alert the end user at the point of care when they access the patient record, that that patient is overdue for a service.

Chip Hart - PCC- Public Member

Yes, that's exactly –

Susan Kressly - Kressly Pediatrics - Public Member

That's no different than they do for mammo recalls. Where everybody that does that in the adult medicine, this is our version of that.

Chip Hart - PCC- Public Member

And Dr. Lehmann, for the purpose of lining – we didn't do very well on the things we discussed today but lining it up with some of the other cert criteria, this a big fastball down the middle, because there are a bunch of CQMs related to these things.

Al Taylor - Office of the National Coordinator - SME

Well, yes, some of them. Yeah, this is – so, there is my fastball down the middle. The CQMs that are already defined, including one that is in development on [inaudible] [00:59:29] screening, vision screening. Our electronically specified quality measurements, that then can be CQMs are after the fact. But the same logic parameters can be applied to use decision support, which is the point of care. Point of care determination of meeting the needs. The heavy lift, though, is to identify and electronically specify the rules which historically has been a fairly heavy lift per rule. In order to implement something in the standard way.

Chip Hart - PCC- Public Member

Yes, absolutely true.

Al Taylor - Office of the National Coordinator - SME

Whether it's in quality management or its decision support or it's a combination of both, take a rule, take a clinical practice guideline and make an electronically specified ingestible computable rule engine so the standard is there existing, published. You can certify to it to the ability to compute and report on existing quality measurements. That's what ONC certifies to. What we don't do, we don't certify it rules that don't yet exist. But EHRs who certified as CQMs can ingest can calculate and report on using the standard languages that we use for CQMs.

Chip Hart - PCC- Public Member

Your comment implies, or one implication of your comment though is, and Dr. Lehmann, this is for you, one of the things that we may want to do at the academy level is taking the periodicity schedule and actually do the work. I don't think it's that hard. It's certainly a fraction of the effort required for the immunization logic. And take the bright futures periodicity schedule and turn that into a computable standard that we can all adhere to.

Al Taylor - Office of the National Coordinator - SME

I mean, I would love to.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

You're preaching to the choir. And I will have that discussion with you off-line. I have been pushing on the partnership for policy implementation to work on this for quite a while.

Susan Kressly - Kressly Pediatrics - Public Member

They get stuck on if the kid is late, what's the bounds of it, but we have to put a stake in the sand if we are going to advance this work and now, we have a reason to do it.

Al Taylor - Office of the National Coordinator - SME

And the good news is that the technical infrastructure is in place to support this. There are also some precedents to doing some of the bright futures guidelines. They are already there, they are already in place in some cases and so it is just a matter of picking up the ball and running with it as opposed to figuring out where the game is going on.

Chip Hart - PCC- Public Member

I'm going to keep that one.

Al Taylor - Office of the National Coordinator - SME

You can use it, I just made it up.

Chip Hart - PCC- Public Member

It was a good one.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

As far as sports analogies go, yes. All right, any additional discussion about this particular item? All right. If not, then I'm going back to my thing, that means we have reached the recommendation 10. And that is the recommendation called flag special healthcare needs. The description was the systems shall support the ability for providers to flag or unflag individuals with special healthcare needs and complex conditions who may benefit from care management decision-support, care planning, and child support reporting. So, this is the use case of flagging your kids that have asthma, your diabetics, kids with specific care coordination problems such as genetic diseases. And use that and really what is implied here is not only are you supposed to be able to flag it, you should be able to use it for decision-support. So, it is something that allows you then to either generate lists, invite people to the office, create health reminders, etc. So, this is something that is going to be the basis for ongoing clinical decision support. All right, I'm going to pause here and see whether there are any thoughts or comments.

Al Taylor - Office of the National Coordinator - SME

Chris, this is Al again. I think number 10, the requirements, the recommendations or requirements for number 10, from a technical standpoint are identical to recommendation number nine. These are the special healthcare needs of a two, four, six-month-old are at a base the same a special healthcare needs of some other population of kids. And so, it's just a matter of defining that with a set of codes and then applying rules about what you do with special healthcare needs. And so, the same thing goes back to the special healthcare needs have to be defined. Guidelines developed and then decision-support and quality measurements built around it, just like the one before.

Susan Kressly - Kressly Pediatrics - Public Member

So, I read this differently and in having done medical home health, three iterations over 10 years, what I think there are individual populations and most EHRs can be able to sort by individual patients that have x diagnosis and create evidence-based care plans around them. That was written in the last certification requirements. What is harder is there is no "ICD" or "SNOMED" code that says a child with special healthcare needs. Some of us are trying to figure out what is our population, our overall population of kids with special healthcare needs however you decide to define it. And people are struggling especially when we start exchanging data to identify. I would love to see that there is a SNOMED or an ICD or both, because some systems use one or other, and current mapping is not one to one. That there is a code that is a child with special healthcare needs. And the practice can decide what other subsets fall underneath that. Just identifying those kids through care coordination and knowing if I get data from Chip's system that says this is a kid that the last practice, as I said, is a kid with special

healthcare needs I pay attention to it differently because there are not good evidence-based guidelines in an overarching way to currently decide what to do with those kids.

Al Taylor - Office of the National Coordinator - SME

But isn't there, is there any single status of special healthcare needs that defines a specific thing to do with the kid? It seems like that is too generic to say that this kid is special, or has special healthcare needs rather than a list of special healthcare needs like diabetes, asthma, obesity, and those codes exist. And then, dealing with each of them is different, I think.

Susan Kressly - Kressly Pediatrics - Public Member

So, those codes do exist and most EHR's because they had to do it for the last certification have the ability to use evidence-based guidelines, the site where they came from, etc. The problem is for pediatrics, it's not diabetes and whatever, it is I have a genetic 22Q11, undiagnosed myopathy, those sort of squishy kids that don't fit in a, and there is no evidence-based guideline to deal with all of these rarer, but – or it may even be that the kid's special healthcare need is that their parent is – has mental health implications and they are at higher risk and need to be followed with a care coordinator or something. I don't know where we want to go with this. But I sort of feel like some of this is already doable, based on the last certification. What's not there is what is – how do you determine who your kids with special healthcare needs are when you're dealing with 27 diagnoses, some of which are squishy and don't have a care plan other than I've got to give this kid a care coordinator who gets to know the mom and helps them navigate the healthcare space.

Al Taylor - Office of the National Coordinator - SME

So, you're talking more of a generic flag?

Susan Kressly - Kressly Pediatrics - Public Member

Yes.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

And the way I look at it was also the ability to determine what it is your flag. You know, you might live, for example, in a community that has a great percentage of a certain type, a certain ethnic group that has a higher prevalence of one particular disease. So, you need to be, as a pediatrician, you need to be able to use that flag and adjust it to your practice's needs. That's how I perceive that. So, it's a more generic ability to create these flags with, then the ability to build decision-support on top of it.

Susan Kressly - Kressly Pediatrics - Public Member

And again, to be able to transmit that in a coded way that from system to system people understand this is a child with special healthcare needs. They may review the record and decide, according to my criteria, no, and you know, retire that problem item or whatever. So, what I hate is that in order to make this happen and a lot of systems to support identifying kids who need more intense care, there is one more checkbox, right? And checkboxes from my system to your system is meaningless. There has to be some sort of coded way to say, this is an identified child with healthcare needs. And quite frankly I think it belongs with a – I would hate it to be just a flag unless we can figure out there is an HL7 or something flag that we can navigate somewhere to do it.

Al Taylor - Office of the National Coordinator - SME

Well, so, what I can say is, if there's not a code, and I – I mean, the research is fairly easy to figure out if there seems like there is an appropriate code in existence. If there is not one in existence, making one is not that difficult. A generic flag, if the industry agrees that a generic flag is appropriate, a generic code flag ICD-10, SNOMED, both, is a fairly low lift to do. There's a well-defined process to introduce new codes.

Susan Kressly - Kressly Pediatrics - Public Member

Then let's make it happen. Chip, am I out of – am I speaking crazy here, or how do experience it?

Chip Hart - PCC- Public Member

No, I remember specifically these last two items appearing at the end of our meeting in October 2017 because we had gotten to the end of the day and we had, I'm going to be obnoxiously biased here, we were looking at a series of inpatient hospital requests. And I said wait a minute how can we talk about having, Sue, you and I were both saying how can we talk about having a pediatric functionality that doesn't fundamentally first all have any preventive care concepts in it, and any sort of chronic disease management concepts in it. The previous items really have very little of that. And so, this, in a way, I don't care where we start on this. Because Sue, your points are absolutely right, there's – this is the tip of the iceberg. We don't want just a generic flag. And we want a lot more than that. We want standards for indicating this kid is diabetic, this kid is depressed, this kid is whatever. But in the absence of nothing, I'd want to – I'm going to start somewhere. So, I haven't said anything yet because in a way I don't even care where we land. Because it would be just the first step and whatever we describe here, Sue and I, in fact, most EHR's have already been doing this for a long time. But putting a pediatric face on it, that will be the important part. I hope that makes sense.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

All right. This is ambitious but I think it makes a lot of sense and I think we have done it in a number of ways. Are there any other thoughts, any other comments to this? And I think, Al, just to go back to your point earlier, yes, I think this is also something that could be used for quality measures. At least for some of them. If they are associated with specific conditions. But, so, it wasn't completely out of the ballpark.

Al Taylor - Office of the National Coordinator - SME

Then, the other thing I would say is if – so, it sounds like I heard two different things, one is a generic code is okay and one is maybe it is not ideal. But the alternative could be to – if a list of quotable concepts can be generated which qualifies as special healthcare needs in general, then – I know just having diabetes doesn't necessarily make the kiddo a special healthcare needs kid, but it might in certain circumstances. But putting together a value set of coding that incorporates this and if a member of this value set, then case management is a fairly straightforward rule to implement.

Susan Kressly - Kressly Pediatrics - Public Member

So, can I get really bold now and say it would be awesome if we had a child with special healthcare needs and there are sub-codes? One is physical needs, one is social determinants of health which can put kids of the special healthcare needs and one is mental health needs? That would be fabulous.

Al Taylor - Office of the National Coordinator - SME

I think that finding, what you are describing is generally held within the ICD-10's e-codes. And there is either a reasonably appropriate spot for them or a reasonably appropriate room for them. That can be developed. And we can – I will do a little bit of research and look around and see where there is some kind of reasonable spot for developing such a code.

Susan Kressly - Kressly Pediatrics - Public Member

Thank you.

Chip Hart - PCC- Public Member

And I would just second Sue, the implication of something Sue just raised, which is to have a top 10 pediatric list of pediatric features, we would be remiss to not somehow pull the concept of the mental health, the growing mental health crisis with kids into it because it is the tidal wave that is hitting all the practices right now. So, even if that is not – she's not trying to solve the mental health crisis with this one little sub-comment, but being able just to say, hey, if you're pediatric you're going to start to – you're going to need to start to track these kinds of things. I think that's a great first easy step.

Susan Kressly - Kressly Pediatrics - Public Member

And one more thing, if we are really going to get to value-based payment for kids, this is we know probably half of their risk and we know that it is currently not at all being calculated by payers and risk adjustment coding. We know your mental health of your parents and so for example, if you look at the SNOMED and ICD code sets, we get stuck with it is really the mental health of the parents that are making the kid's special child health needs. But it – does it belong on the – you don't want to put the mom's diagnosis on the kid's problem list, and there is no code set for a parent with, right? So, when you look at those code sets, please do so with that in mind.

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

This is probably a good time to just take a quick break for public comments before we wrap up today's discussion. Operator, can you please open the public line?

Operator

Yes, thank you. To make a comment please press star one on your telephone keypad and a confirmation tone will indicate your line in is 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 keys.

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

Thank you. And do we have any comments in the queue at this time?

Operator

No comments at this time.

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

Okay. I will hand it back to our co-chairs to wrap up the discussion for today.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Well, I think we have done quite a bit of work today. Managed to go through four recommendations. I am at this point very appreciative of all the comments and the discussion. I think there is a lot of work that we identified for ONC to go back and do some research on and identify potential ways of solving this. And I am very grateful and appreciative for everybody on the call today and I am going to turn it back to Carolyn.

Carolyn Petersen - Individual - Co-Chair

Thanks, Chris. I want to second Chris's comments about all the great work that was done today. I feel like we really teased out, well, you really teased out a lot of important issues and things that are perhaps not immediately apparent and to people who are pretty involved in developing EHR's, which is wonderful. I did want to touch on one comment that I heard in the discussion earlier. Someone said they thought we hadn't done very well on the first two guidelines. To the contrary, I think you had done a tremendous job in particular with some of the very challenging discussions we have had today.

Chip Hart - PCC- Public Member

That was me. I'm sorry, I only meant we didn't – we glossed over the of tying it back to other things. That's all.

Carolyn Petersen - Individual - Co-Chair

But from the HITAC perspective, what is really beneficial for us is getting all of these things surfaced and on the list of consideration and things that ONC needs to think about and perhaps things that developers need to start thinking about in their work. And so, it is, it's not a problem if we don't just kind of talk about things and agree and say yes, we will keep it, it's all good. The value is in pulling all these things out and finding the deviation from where we thought we were three or four years ago. I believe the whole HITAC will be very appreciative even when we are not agreeing or just rubberstamping what's in front of us. So, please –

Susan Kressly - Kressly Pediatrics - Public Member

Thank you for that comment. I am a full believer that if everyone at the table agrees with each other we've just invited the wrong people to the table we are all just adding to our affirmation bias without having richer discussions. So, thank you for pointing that out.

Carolyn Petersen - Individual - Co-Chair

Thank you for all of your hard work and I will now turn it back to Lauren. Do we have anything else?

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

No, that is it. Nothing else from me. Thank you, Carolyn. And I think we already have our next meeting on the books.

Samantha Meklir - Office of the National Coordinator - SME

This is Sam. I don't know if Stephanie Lee - Office of the National Coordinator - Staff Lead has anything to add. I just wanted to take about 30 seconds for a process, if that's okay. So, for our next call, just taking a few moments perhaps to the extent that any members of the task force identify any of the supplementals that they would recommend removal of as a correlated item to the larger recommendation, that would be helpful to identify. I believe in our first call, Chip you had identified supplemental number two to recommendation number two. If there are other examples, we just want to circle back and identify those as a group and then additionally, if there are any correlated existing or proposed criteria that should be removed, we can identify them as well. I don't think this will take very long. And it seems as though there is a consensus from today's discussion to retain all 10 of the ONC recommendations as well. So, I just wanted to offer that.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

I think that's my impression from the discussion thus far as well.

Susan Kressly - Kressly Pediatrics - Public Member

Agreed.

Samantha Meklir - Office of the National Coordinator - SME

Thank you. And we additionally – on the last call there were some clarifying for ONC on DSP, and AI, we do not have time today but we are prepared to respond to those, and then that obviously will be helpful as we dive into a focused DSRP discussion regarding the larger proposal in the rule outside the care continuum section of the NPRM that is scoped to the task force charge as well.

Samantha Meklir - Office of the National Coordinator - SME

Stephanie Lee - Office of the National Coordinator - Staff Lead, did you have anything to add in terms of work plans or future calls to share with folks at this time?

Stephanie Lee - Office of the National Coordinator - Staff Lead

No, I think you covered it all. Thanks, Sam.

Samantha Meklir - Office of the National Coordinator - SME

And I just want to thank Stephanie Lee - Office of the National Coordinator - Staff Lead again for taking notes while we do this. It is a hard task, and she has done a tremendous job and we're very appreciative. Thanks, Stephanie Lee - Office of the National Coordinator - Staff Lead. And Stephanie Lee - Office of the National Coordinator - Staff Lead, in keeping with what we have done following other meetings as I understand we will make this available to members via Google docs so that they can review and refine accordingly. Is correct?

Stephanie Lee - Office of the National Coordinator - Staff Lead

Yes, they will always be available online.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Wonderful.

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

Thank you. Thanks, everyone.

Cassandra Hadley - Office of the National Coordinator - HITAC Back Up/Support

Thank you.

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

Have a wonderful weekend, thank you all so much for the rich discussion and your time.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Thank you, I appreciate it.

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

Bye-bye.

Chris Lehmann - Vanderbilt University Medical Center - Co-Chair

Goodbye.