



# U.S. Core Data for Interoperability Task Force

Transcript  
April 15, 2019  
Virtual Meeting

## Speakers

Name	Organization	Organization Type
Christina Caraballo	Audacious Inquiry	Co-Chair
Terrence O'Malley	Massachusetts General Hospital	Co-Chair
Tina Esposito	Advocate Aurora Health	Member
Valerie Grey	New York eHealth Collaborative	Member
Ken Kawamoto	University of Utah Health	Member
Steven Lane	Sutter Health	Member
Leslie Lenert	Medical University of South Carolina	Member
Clem McDonald	National Library of Medicine	Member
Brett Oliver	Baptist Health	Member
Steve Ready	Norton Healthcare	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Stacy Perchem	ONC	Staff Lead
Adam Wong	ONC	Back Up/ Support
Johnny Bender	ONC	SME

**Operator**

Thank you. All lines are now bridged.

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

Good afternoon, everyone. Welcome to the USCDI task force. Quick roll call – I know we have our Co-Chairs, Christina Caraballo and Terry O’Malley. We also have Tina Esposito and Steve Ready. Are there any other task force members that are on the line? Okay. I see a few that are dialing into the Adobe. So, maybe they’ll be joining us shortly.

So, with that, I will turn it over to Christiana and Terry for a few opening remarks before we dive into the discussion of the recommendations.

**Terrence O’Malley – Massachusetts General Hospital - Co-Chair**

Okay. Christina, do you want me to start?

**Christina Caraballo – Audacious Inquiry - Co-Chair**

Go for it. Thanks, Terry.

**Terrence O’Malley – Massachusetts General Hospital - Co-Chair**

All right, gang. Welcome back. We had a really good HITAC meeting last week with a lot of really important feedback. So, our job today – we have several jobs, but our main job today is to go through that feedback and edit our slides because the slides are going to be the basis of the transmittal letter, which we have to get approved at our next phone call.

So, we’re on a little bit of a tight timeline. The plan is today to go through the comments and then what we said and then edit that. Hopefully, we’ll get through all five sections. There are a couple of interesting issues that came up as a result of the HITAC, but we can discuss those. So, without further ado, shall we set off into the slides? Johnny, are you going to share your deck?

**Johnny Bender – Office of the National Coordinator for Health Information Technology - SME**

Yeah. So, I shared – is everybody able to see the screen? Okay. Great.

**Terrence O’Malley – Massachusetts General Hospital - Co-Chair**

So, the way the slide deck is arranged is we’ve got those five sections. The demographics, provenance, clinical notes, pediatric vital signs, and others. We’ve pulled in each section – so, the questions that we had for the HITAC, their comments and then what we said and that will be our chance to edit. Before we go any further, any questions or concerns or comments?

**Tina Esposito – Advocate Aurora Health - Member**

No. All good.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. We'll take it through. So, here's what we asked the HITAC. Were there any other use cases besides three? We actually didn't get a lot of feedback from them on our particular question, although we did get some feedback.

So, basically, Andrew and Clem and Arien commented. I think that by and large, Andrew's comment on the role of patient care, we decided we'd put in our other category, since it has to do with team members. We'll pick that up when we get to our last other. Clem's comment on NPI actually fits well when we get into provenance, although he was also an advocate of cellphones. Andrew was more of an advocate. Arien's comments we're moving over to pediatric vital signs.

So, next slide, please – thank you for your rapid-fire edits, Johnny. Much appreciated. We didn't really get a lot of comments on the initial address. I think that can pretty well stay the way it is unless people have – again, anyone with a comment or a concern, just speak up. Don't worry about putting your hand up and having us see you. Just break in and say whatever you want. Both of those, the phone number and the address were pretty much unscathed.

Next slide, please, Johnny – okay. The only feedback we got on the preferred email address was from Steve Posnack, who wasn't quite sure that this was really an address, but we're going to float it out there anyway. No one else in the HITAC made any comments about it.

The next section under other was where most of the comments came. They really came one, as sort of the optional identifiers, and the first one was in pediatric demographics. So, for pediatric demographics, there is an issue that Steven Lane raised. Steven, are you on the phone? I think I saw an email that he was going to miss this. But Steven raised a really interesting point, saying, "Is there a more general use case than just pediatric demographics? The constant seems to be any individual who does not have the capacity to consent, either for treatment or use of information."

That's particularly true in pediatrics. It's really complex because you've got different ages of majority. You've got different degrees of competency and then you've got the issue of emancipation. So, if you're married at the age of 13, you're an emancipated minor and free to make your own decisions. So, it gets a little complicated.

But the flip side of that happens at the other end of life, where you've got individuals who no longer have capacity usually because of dementia. They need sort of the same thing in their demographics. They need an indication of who's got consent authority and how do you get in touch with them. So, let me throw that out to the task force and get some thoughts on whether we want to broaden pediatric demographics to include really anyone who does not have consent authority.

**Tina Esposito – Advocate Aurora Health - Member**

Terry, this is Tina. I think that's an excellent point. I wonder if it would be worth maybe commenting for further clarity on what the intent is, sort of the bigger picture. I agree that

would fall under demographics, but I think we're making some assumptions here and perhaps part of the comment would be that if the intent is to provide clarity around the items that you just identified, then that needs to be clarified and ensure that that's incorporated as part of the ultimate solution or final rule, if you will.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Thank you. By all means, we'll draw up some context around that. I heard someone else.

**Steve Ready – Norton Healthcare - Member**

Yeah. This is Steve Ready. I was just going to say it would make sense that if much as possible, if we can broaden that section to expand beyond the pediatric piece, I would agree.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Right. Okay. Anyone else? That was easy. Okay. Great. We'll craft some context around that and make it less pediatric. Okay. So, the next comment was actually from Andrew Truscott around some clarity around what you mean by a vetted ID. Adam had a great phrase for it. It says, "A vetted ID is issued by a state or national authority, such as state driver's license..." and that whole list of things there.

So, among the non-vetted – so, your last four digits of your social are sort of a vetted ID, since you get it when you're born. The direct address is not a vetted ID. So, maybe we – anyone have any strong feelings about keeping it direct address or putting it under a different heading?

**Clem McDonald – National Library of Medicine - Member**

This is Clem. I think that having a way – I think I've talked about it before – some address by which an organization could push the data to that individual's preferred site would be very advantageous. A direct address is one example. Email address is another, which would also require a field to say I give permission because that's allowed already. There may be others. We really need a way to deliver the detail to the patients by push, rather than have them chase around and figure out how to get to it.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

That's a great point. So, direct address is just one of several means of pushing data to the patient. Others would include their email. It might have a PHR address.

**Tina Esposito – Advocate Aurora Health - Member**

I'm wondering if we don't move the direct address up with the email address.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

With the email address or the email address down to direct address?

**Tina Esposito – Advocate Aurora Health - Member**

Yeah.

**Clem McDonald – National Library of Medicine - Member**

But this is a little different. It's not just giving the email address. It's saying send it to this place. With the email, you probably need to have an additional field that says, "I authorize my provider to do so," because in many contexts, people are nervous about email addresses because they do present some risk for being snooped on.

**Steve Ready – Norton Healthcare - Member**

Yeah. Unless it's sort of a secure – that's an issue.

**Clem McDonald – National Library of Medicine - Member**

Well, direct actually adds security, but it's another burden and it's a barrier, but currently, according to the meeting last week from Steve Posnack, currently, providers are supposed to allow the discussion or delivery by email if the patient requests it. So, we need an additional field or something that says they requested it so that those patients that are really nervous about having their hemoglobin go through email would not specify.

**Christina Caraballo – Audacious Inquiry - Co-Chair**

So, I think that's an excellent point. Keeping us focused on the data elements, I definitely agree that the preferred communication method is important, but looking at the specific data elements for our purpose, I think it's sticking with those.

**Clem McDonald – National Library of Medicine - Member**

Wasn't email already on? I thought it was.

**Christina Caraballo – Audacious Inquiry - Co-Chair**

It was. They're looking at putting them in the same category.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Tina, your phrase of preferred communication method, maybe that's another line that needs to be in demographics. It can be a dropdown.

**Clem McDonald – National Library of Medicine - Member**

Focus on preferred push delivery method.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay.

**Clem McDonald – National Library of Medicine - Member**

There's a difference between a number that you would call a patient to remind about an appointment and the clinical data.

**Christina Caraballo – Audacious Inquiry - Co-Chair**

Excellent point.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

So, more verbiage around that. That's excellent. Then no one really had any comments about homelessness and weighting those standards and gender identity. So, I think we'll leave those on, recognizing they're going to be a second stage set.

**Clem McDonald – National Library of Medicine - Member**

I think that's fine. But also, realize homeless, it's hard to have – there's an intrinsic problem. Gender identity, I think stuff is being proposed and cooking for a set of questions and answers about that. In some domain, it will be coming our way.

**Steve Ready – Norton Healthcare - Member**

Actually, I think Sequoia is working on homelessness.

**Clem McDonald – National Library of Medicine - Member**

Oh, good.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

It's not just homelessness in general, but people who are displaced by natural disasters, a whole bunch of people. I think we'll make it clear that we're saying in a second tier as soon as standards are ready, we would like to bring this forward. Okay? So, if we get to the next page, it's sort of our set of recommendations. I think we'll rewrite this to reflect the comments that we just had and really tighten this up to make it a bulleted set of recommendations. So, it won't be a discussion of recommendations, it will be recommendations.

**Clem McDonald – National Library of Medicine - Member**

The last four Social Security was on the last previous stage, right?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Right.

**Clem McDonald – National Library of Medicine - Member**

That's still in play?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Yeah. For the use case of patient matching, the vetted IDs are really voluntary. They're not going to be required. You would think a system should be able to capture it if it's available. Okay. All right. Patient demographics – that's a wrap. So, what we're going to do is we'll write this all up and we're going to put it in the two formats.

One is the slide deck that we're going to show on the 25th and the other is in the transmittal letter. We'll get the transmittal letter out to everyone as quickly as we can. So, you'll have a chance to look at it so we can vote on it as a task force next Monday. So, that's the plan. We'll recraft this stuff. We won't add anything new. We'll just try to clean up the language a

bit.

Moving right along, provenance – we actually got a fair amount of comments on provenance. I think generally, it was very supportive. So, let's go to the comments. Next slide, Johnny. So, Steven's comment was to clarify the issue around author, organization, entity, agent, and his recommendation really was start at the very highest level, where there is some clarity. That is to just ask for the organization that generated the particular data element in question, recognizing that if it's a big organization, they may have many, many layers underneath it.

What we want to know in provenance is that this data element came from a reputable source. We can find that source and that source can find a data element and give us its provenance, its history within their system. So, that was what I took as Steven's comment. It was in response to Sasha Termaat's comment that it's really hard to sort out agent, entity, author.

Steven's point was don't go to that level. Keep it at a really, really high level as the first cut and a second pass at provenance, you will have some experience about knowing how valuable further granularity would be. That's what I took from Steven's comment. Let me toss that back to the group.

**Steve Ready – Norton Healthcare - Member**

This is Steve Ready. I wasn't able to attend the meeting, but I have a question. Around these two data elements between organization versus author, was there any discussion around legal liability from an information discovery perspective during a lawsuit or anything like that of what's mandatory to be there or what an organization must be held liable and must produce for provenance for an organization that sent the data? Was there any discussion around that?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Not that I recall.

**Steve Ready – Norton Healthcare - Member**

Okay. Thanks.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Should we? We're the task force. We can do whatever we want.

**Steve Ready – Norton Healthcare - Member**

I didn't know if some legal consideration needed to be discussed from an attorney perspective of what's going to be required to be discoverable if clinical decisions are being made, if something happens, if harm has occurred, if they're going to want to discover the author of some bit of discreet element that was shared.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

I hear your point. I think some time in the future, we might get down to that level of granularity, but I think that Steven's point was let's start it as simply as we can in a way that

is effective and gives us the trust we need if the data element is there and gives us the ability to find it if we need to.

**Steve Ready – Norton Healthcare - Member**

Okay. Sounds good.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

So, I think what we're proposing to do – if we go to the next page, Johnny... So, what we're really proposing is the organization and the timestamp without the author and without the agent or entity. I think agent/entity just confuse things a bit. So, what we would say is no author. We would have instead of the author's timestamp, we would have the organization's timestamp. That's the source organization.

**Steve Ready – Norton Healthcare - Member**

Makes sense.

**Clem McDonald – National Library of Medicine - Member**

Just a clarification – the timestamp is related to what?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Creation of the data element.

**Clem McDonald – National Library of Medicine - Member**

I think you have to go further because there's a date that it's created – say in a lab, something could be produced if something else happens and it doesn't get released until it's finalized. We should investigate what's the precise one that's most relevant. An instrument might pick it out, but it doesn't count as real until a technologist reviews it or something like that. I think its release date is what's used in HL7. We should clarify that.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Let's put that in. That makes perfect sense. It's going to be an identifier that the organization knows. They're going to know the release time, release date. They can track it back using that. So, timestamp really means the release date.

**Clem McDonald – National Library of Medicine - Member**

If you're precise, it means release date and time.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Great. And the organization is the organization within which that data element was generated.

**Clem McDonald – National Library of Medicine - Member**

Correct.



**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Which then carries on to some of the other discussion we had about unique identification and a versioning identification. We can get to that next. I think this a bit clearer.

**Tina Esposito – Advocate Aurora Health - Member**

I would agree. I think if we take the meaning of provenance in terms of what it's intended to do, it's just to tell you the source. I think we're trying to go down a little too deep. Starting at this level, it tells the user, whoever that may be, "Here's where this is from," and if we incorporate some sort of timestamp, date, whatever, I feel that's a fair first step.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

That's great. Then Clem, to your point, do we want to put in the organization as indicated by NPI or is that getting too specific? Clem, if you're answering, you're on mute. Maybe we've lost Clem. So, for the rest of the group, what do you think about using NPI as the organization tag? Clem has disconnected. Okay.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

This is Sheryl. That works for provider organizations, but what if they are other than that?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

According to Clem, anyone who bills Medicare or Medicaid has got to have an NPI number.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

What if you're exchanging data with a payer? To my knowledge, we don't have an NPI number.

**Christina Caraballo – Audacious Inquiry - Co-Chair**

That seems to be attached to the provider, not the organization.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

To me, the standard of what should go in there is somebody else to figure out. I think for us, it's to figure out what the data element should be. For provider organizations, I think NPI is the right one. For us, maybe it's our corporate number. We do have those as well. I don't know the right thing. I think that's for the standards organization to figure out, right?

**Christina Caraballo – Audacious Inquiry - Co-Chair**

Terry, I think the NPI is going to be more in optional recommendations under the provider demographic.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Dr. McClure made a comment, but I can't see it right now. It flashed on the screen for a second. Johnny, do you want to take us to the next one?

**Christina Caraballo – Audacious Inquiry - Co-Chair**

So, Dr. McClure said an NPI can either be a person or an organization. There are two different types of NPIs that look similar.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. So, under our additional recommendations, we're scrapping all of this – well, all the top part. So, we're not going to get more granular. We're going to stay very high-level. So, that one goes. But there was a universal appreciation of a unique and persistent either identity or identifier. I'm not quite sure I understand the difference between the two, but if somebody else does, I'm happy to...

**Clem McDonald – National Library of Medicine - Member**

I think if we just talk about an organization, I think it's an identifier.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. So, we're okay with identifier?

**Steve Ready – Norton Healthcare - Member**

Yeah.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. So, great. How about instead of instance or observation, we just use data element, which is what ONC has used all the way through.

**Clem McDonald – National Library of Medicine - Member**

I think the use of the word data element is really a messy term. In database terms, you can make an individual field, like the dates of an observation or the units of measure. It doesn't mean the whole thing. The things we're talking about are mostly chunks, like a prescription or an observation. I don't know if there's a good word for it.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Yeah. But the way ONC has been using it, they're not using it in a database terminology. They're using it from a user perspective, I think.

**Clem McDonald – National Library of Medicine - Member**

But it's very confusing, as a result. Maybe we should talk to them.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. Do you have any substitute?

**Clem McDonald – National Library of Medicine - Member**

Well, the data item might be more generic. That's what they call the parts of a survey instrument, typically, the individual questions.

**Christina Caraballo – Audacious Inquiry - Co-Chair**

This is something we went back and forth on in our first round of recommendations. I think if we have time, we should come back to it at the end. I just say let's align with the ONC definitions for the purposes of getting through our recommendations today. When we move on to the expansion process, we can continue to highlight definitions as an issue.

**Clem McDonald – National Library of Medicine - Member**

Have they defined it in their material?

**Christina Caraballo – Audacious Inquiry - Co-Chair**

They have. Data class, data objects, and data elements were defined.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Thanks, Christina. Okay. Johnny, how about the next one? What are we doing?

**Christina Caraballo – Audacious Inquiry - Co-Chair**

Data class and data elements have been defined. Thank you.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Let's replace everything with data class and data elements where appropriate, whichever. We're getting rid of patient and entity, getting rid of the author. Then we had a discussion of the recommendations. Here's where we're going to mark things up a little bit. Again, Clem, I think it was your point. We said let's start with the who and the when. We'll clean this up to be organization and release time.

**Clem McDonald – National Library of Medicine - Member**

Yeah. Most of these data elements that we go with have that [inaudible] [00:33:18] inside of them.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Won't it be useful in provenance? Don't you think?

**Clem McDonald – National Library of Medicine - Member**

No, I don't. What's the point if they come as pairs. Provenance applies to what we're calling data elements. Let's say if you take an observation, there's already a variable called category. There's a variable called the observation identifier. The observation identifier points to a dictionary, which says even more things about it. I think it only adds confusion if people have to say, "Pizza, pizza." Often, they'll say it two different ways and it creates even more confusion.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. So, you're saying forget about the what. It's already part of the data coming. The data that's coming to you is already flagged by the what. So, we may want to say that.

**Clem McDonald – National Library of Medicine - Member**

It's a thing that says something about the data element. It's not standalone.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Let's make the point that they're going to know the what is, even though it will come as part of provenance, as part of the data package or whatever.

**Clem McDonald – National Library of Medicine - Member**

Correct.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. A lot of the stuff on here I'm not sure we need to include, like that one. Again, we're going to rewrite the second bullet to make sure that whole idea is included. I'm not sure we have to tell them that subsequent versions can be expanded because they will be. We're just citing a use case, but it's not...

**Clem McDonald – National Library of Medicine - Member**

I think some people don't realize that that could even be the most important way. There is so much duplication in these electronic flows to know which one to pay attention to.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

So, we'll figure out where to put that one. If it requires a new metadata field, do we need to point that out?

**Clem McDonald – National Library of Medicine - Member**

I'm sorry?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

So, the next line, where it says, "Unique identifier may require a new metadata field?"

**Clem McDonald – National Library of Medicine - Member**

Well, it could. If one depended on something that's already there, you want the first one to be in its own field. Actually, this is a little premature. We need to talk with some of the FHIR experts to get clarity on the best way to do this. I have a call scheduled later tonight. It didn't happen soon enough to help this call – to get clarity on what's cooking or could be there.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Should we just defer to HL7 and say they'll figure out the metadata?

**Clem McDonald – National Library of Medicine - Member**

Yeah.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

We'll do that. We won't care. The last paragraph is where we can put a little piece about organizations and what we mean by an organization and perhaps what we mean by the release time, the timestamp. Great. I've got too much paper on my desk. Moving right along, clinical notes – this is great. We're rolling.

Okay. So, this is an interesting discussion, I thought. Do you want to hit the next slide, Johnny? There was a wide range of opinion, including Steven saying, as the rest of us did, it makes sense. There are note types in the consolidated CDA.

Steve Posnack says yeah, but the market hasn't implemented most of them. If the secret were to be known, the reason the market didn't implement them was not that it didn't necessarily have value, it's because the CCD allowed you to check all the meaningful use boxes and get paid. So, CCD had more value. It doesn't necessarily mean the other note types don't have value, at least that's how I read this.

**Clem McDonald – National Library of Medicine - Member**

I'm not sure what the exact points were, but most of these notes, not all of them, exist in a dictation system today or in a computer system today. The challenge may be making sure they're labeled as such. What's already specified in CCD is likely to also be in a computer system somewhere. We did add some that may not be widely used and I don't know whether that's Steve Posnack's point.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Transfer summary is not widely used. There are discharge summary and CCD. On the other hand, the transfer summary has a lot of clinical value. The note types weren't chosen for their clinical value. They were chosen for their meaningful use value, which is different.

**Clem McDonald – National Library of Medicine - Member**

I think they were chosen for what kind of existed then. Everybody does an operative note. Everybody does a discharge summary. Maybe we just put it out there and see what happens. I don't know whether we have to be too precise. I'm supportive of the list we put in. Maybe the industry won't adopt them.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

How about a recommendation that if you generate any of these things, if you generate operative notes, if you have discharges, if you send out lab value narratives and pathology, that you adopt these note types? If you don't –

**Clem McDonald – National Library of Medicine - Member**

Well, the lab one is the one that worked for me. Yeah. That may be a reasonable compromise.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Just say if you make it, if you do this stuff, then send it this way. If you don't, then don't

worry about it because you're not going to need to do it. On the other hand, if you're a receiver, you've got to be able to receive all of these documents. It's a different thing. You've got to be able to receive them, parse them, put them into your system, retrieve them, send them back again. So, the onus is really on the receivers.

**Clem McDonald – National Library of Medicine - Member**

Just to clarify, though, the joint commission requires some of them and they'll never go away. They'll always be there.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Do you think it's a reasonable compromise to say that if you generate these types of notes, then send them...

**Steven Lane – Sutter Health - Member**

Terry, I don't know if you're using the hand raising feature. This is Steven. Sorry.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

No, Steven.

**Steven Lane – Sutter Health - Member**

I joined late because they scheduled a bunch of patients on top of this meeting. I apologize for that. I think your compromise makes sense. I do think that we want to encourage systems to label notes by the standard set of note types. We don't have to require the use of things that the market has not proven valuable.

It's a shame if everything gets labeled as a miscellaneous note because only by labeling them can the receiving system really try to do something intelligent with them in terms of where they filed them and who they send them to and how they expose them, etc. Having a list of core note types that are somehow required and others that are optional, but if you have them, you should send them and everyone should be able to eventually receive them and make use of them, I think that makes sense.

**Clem McDonald – National Library of Medicine - Member**

I think your point about the miscellaneous notes being not really helpful because you don't know what it is is a really good one.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

That makes specifying and using these note types, to your point, Steven, it makes it even more valuable because as, I think, Arien suggested, you needed an unstructured note. That ought to be a miscellaneous note, I'm sure. We need that.

**Steven Lane – Sutter Health - Member**

Unstructured and miscellaneous are a little different. Unstructured is you can just throw different kinds of content in there, whereas miscellaneous, I'm sort of thinking about is it an

op note, is it a discharge, is it a consult, etc. But I think probably both of those are going to be needed.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

An unstructured and a miscellaneous?

**Clem McDonald – National Library of Medicine - Member**

Unstructured – all the narrative notes are unstructured by definition in the description from the USCDI. It's just talking about labeling them clearly. I wouldn't argue that you must have a miscellaneous note. It may encourage everybody to use that as the only note type.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

You just want to make sure the notes can move, that any note can move from a source system to receiving system.

**Clem McDonald – National Library of Medicine - Member**

Correct.

**Steven Lane – Sutter Health - Member**

I'd leave it up to others to say whether that means you need a miscellaneous note type or not. What we don't want is to be able to only ship or access a subset of the notes because then that creates patient safety concerns.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

So, we're going to say then we want all of these – if you're creating a note that conforms to one of these HL7 note types, then send it as that type of note, right?

**Clem McDonald – National Library of Medicine - Member**

Label it and send it.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Label it and send it. And if you don't do that stuff, then don't worry about it because you don't have to do it.

**Clem McDonald – National Library of Medicine - Member**

You'd be better off not telling them what they don't need to do.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Good point. Right. We'll just say what you have to do. That's good. Point taken.

**Steven Lane – Sutter Health - Member**

Terry, I don't know whether you've had a chance to acknowledge the great stuff that's being put in the chat and comments, but I see we've got some real subject matter experts who

have shown up for the call and they're providing input. I do want to encourage those of you who are here from the public, please plan to speak up when public comment time comes because it's very frustrating when we don't have a chance to hear from people directly.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Yeah. Thanks, Steven. Yes. Please, be prepared early and often. Okay. And then Clem, you made the point that if we get enough people doing this, we'll hit a tipping point. I agree. Can we have the next slide, Johnny? Again, I don't think we got any pushback on this, nor did we get any clarification that I can recall about operative notes. So, I think this can pretty well stay. Next one, Johnny?

Okay. So, here's where we made our recommendations and our additions to add the following clinical note type stuff. All that did was to complete the CCDA list. Following the last three, again, I don't know if the standards already exist for the first two, med list and the advanced care planning. Standards will exist shortly for the long-term support. So, again, any further comment on those? We'll probably keep this pretty much as it is.

**Clem McDonald – National Library of Medicine - Member**

I'd like to second Steve. I hadn't been looking at the public comments. There are some very good ones in there. I just read through them.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Thank you to all the folks making the comments. Okay. Let's go ahead with the next one. Where are we at? Okay. So, this is our discussion of recommendations.

**Steven Lane – Sutter Health - Member**

Terry, I forgot – where do you have the recommendation regarding the standard quality metric query response? Was that here? Did you already cover that?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

We put it in other because I didn't know how to put it into here. We didn't get to in the HITAC because I forgot we had one more slide.

**Steven Lane – Sutter Health - Member**

If I'm still on the call when we get to there, I'm going to have some comments just because it's come up in a regional discussion here in California.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. All right. I'm reading Rita's comments in the public chat. Thank you. Please feel free to email us, whatever you'd like. Thank you. So, on our discussion here, we basically concluded that we want all the notes. If you have the data, then you send it in a note and label it as such. We can cut out a lot of the stuff about the transfer summary notes better than the discharge summary.



The next paragraph, the new note types, I think, is an important concept to advance. That is it just can't be hospital, ambulatory, practice-centric. The healthcare system is much broader. We have to begin to recognize the needs of the other service providers as they go from medical to support services.

I think the only other comment was the comment made on the previous slide about the distinction between senders of the data needing to use labeled document types corresponding to the content and receivers be able to use them.

**Clem McDonald – National Library of Medicine - Member**

For the record, most of these note types – and I think there's more than a couple thousand have [inaudible] [00:52:01] that are specified to be used in both FHIR and the CCPA. So, it shouldn't be a challenge to take one more data type in, given it just has a different code. But it's saying that they have to be able to take them.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

The receivers have to be able to take it in.

**Clem McDonald – National Library of Medicine - Member**

I think if the receivers can take any note type, they can take all note types. There's just a matter of a different code on it.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay.

**Clem McDonald – National Library of Medicine - Member**

I still want to quell about the reconciled medications being a separate note. To me, that should specify in the medication item that this one has been reconciled. Steve, what are your thoughts on it? You're going to have too many places to look to find out what they're on and then whether it's been reconciled.

**Steven Lane – Sutter Health - Member**

I think both would be valuable. When you're talking about an individual medication and having some metadata about when and if and by whom and in what context it was reviewed, validated, "reconciled." I think the idea of this is a reconciled medication list. A nurse, doctor, pharmacist, patient, caregiver actually performed a reconciliation on this date and here's the list. I think both of those things have value. I don't know that I would give up one for the other.

**Clem McDonald – National Library of Medicine - Member**

But it's the same information in two different places. I can't see that being helpful.

**Steven Lane – Sutter Health - Member**

I think they're really different use cases, to me. As a clinician, sometimes you say, "Gee, is the

patient still taking lisinopril? If there is a way to check on lisinopril from any system, whether you're asking the payer or the patient or the pharmacy or another provider and there's a little piece of metadata that says, "Well, at least as of January 14th a clinical pharmacist said they were taking lisinopril, but I think that's different than saying who's got the latest reconciled med list and can you please send it to me.

**Clem McDonald – National Library of Medicine - Member**

If you have it attached to the record, you could generate a display to distinguish them. The problem really is too many places, it's really dangerous. They looked at one list and they thought they were on a drug. They didn't realize it was nothing but reconciled or not. I think it's sort of a magnet for errors.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

I hear your point, Clem. The problem is the flip side of what happens now in systems. We use Epic. It allows you to say you've reviewed the medication list. It says nothing in it about reconciling it. So, if you've reviewed it, it's kind of worthless.

**Clem McDonald – National Library of Medicine - Member**

That's a different story.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

It is a different story, but it's part of the same story, I think. Ideally, you'd be able to pull in the reconciled list and stack it up to the one you have.

**Clem McDonald – National Library of Medicine - Member**

I think if the records were marked by drug and by date, you could generate whichever kind of list you wanted. I think ideally, there would be some flags saying this thing was reconciled when you look at your regular medication list. So, you don't have to remember to look at two places and compare them. That's another reconciliation problem.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Are you suggesting that we don't call out a specific medication list, but we call out instead the data that's needed around each medication?

**Clem McDonald – National Library of Medicine - Member**

I would suggest the date, by whom with the other attributes of the medications and their standard risks. You could click to see if those are reconciled or not. You could do it by date.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Then you could build a reconciled list from that. So, what do you think, guys? Should we put that recommendation in the other bucket?

**Clem McDonald – National Library of Medicine - Member**

The other point is I for sure wouldn't make it a note because then it's going to end up in a

different record altogether.

**Steven Lane – Sutter Health - Member**

I think you're making good points, Clem. It's clearly still USCDI. We're talking about medication metadata. So, we have to figure out – presumably, we would put it in with the medication section, which isn't really something we've even been talking about this cycle.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

We can throw it in other and just say, "Speaking of medications, this is what we want for medication metadata." You'd like provenance with your medications.

**Steven Lane – Sutter Health - Member**

Just to be clear, Terry, Epic does have some other functionality around individual medication reconciliation, where a user can say whether they take it, when they last took it, add notes, etc. At least that vendor does – other than just having the checkbox that says, "Yeah, I reviewed the medications," it does go deeper than that.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

I understand. I wasn't being fair to Epic. I'm sorry. Okay. Let's put the medication metadata in other, take out the reconciled meta for simplicity and clarity. Great. Now, we are into pediatric vital signs. We're getting there. I think there was a good discussion about this particular issue that I think Clem summed up very nicely. Send it if you've got it.

**Clem McDonald – National Library of Medicine - Member**

Actually, apropos, I've been meaning to complain about – there is a real risk if someone – it's not just that you have it. If somebody made a decision based on it, you'd like to know what it was when it happened. At least send it when you've got it.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

It's going to be tough to connect the decision, I think.

**Clem McDonald – National Library of Medicine - Member**

If you displayed it, I think you should save it and then you've got to send it. If they displayed it, someone could have made a decision then.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

That's a little different than Steven, what you were saying.

**Clem McDonald – National Library of Medicine - Member**

It's a little stronger. I don't disagree violently with what Steve said, but I do think you have to worry about the documentation because those things aren't always going to be the same. You'd like to know what he would have seen when something might have happened based on it. Bodyweight is a problem in this context. Sometimes nurses put in which bodyweight they put in in calculating a medication dosage. That may be an aside. We've got enough to

do.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

We can drill down on the details of bodyweight and blood pressure measurement and a whole bunch of things as a round two. If we go to the next slide...

**Steven Lane – Sutter Health - Member**

So, Terry, this point about the pediatric vital signs and the underlying data versus the calculated values, I noticed that Dr. McClure included some commentary about that early on. I didn't have a chance to drill down and follow all the links. Hopefully, that can be discussed with public comment. It looks like some work has been done on some of this by HL7.

**Clem McDonald – National Library of Medicine - Member**

I think what he basically said was that you record as another attribute and another observation what thing was used to generate it.

**Steven Lane – Sutter Health - Member**

Terry, was your takeaway from our HITAC discussion that people felt comfortable with our proposal?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

I think the compromise was accepted broadly. That is if you have it, send it. If you don't have it, don't go out of your way to calculate and store it and then send it. Then I think – I'm trying to remember who made the comment about – I think the whole issue of making a clinical decision based on that information, I think that's a step too complicated to us.

**Steven Lane – Sutter Health - Member**

I tend to agree. That is a problem we're going to have to solve eventually, but probably not this month.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Are you okay with that, Clem?

**Clem McDonald – National Library of Medicine - Member**

Yeah.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

All right. So, largely, we'll cut the pediatric vital sign section down. I think Arien said, "I'm going to get confused if you have length and height." How about if we make that the same field. Modify your –

**Steven Lane – Sutter Health - Member**

I think there are really just two different labels for the same thing. I agree with Arien. It took him a while to say it, but he was saying these aren't really two different things. You shouldn't

have two fields. Little babies, we lay them down and stretch them out and measure them and with bigger kids, we stand them up. It's interesting. I don't know that I've ever seen in my system a notation box that says this was done lying down and this was done standing up. I think it's really the same field.

**Clem McDonald – National Library of Medicine - Member**

There are fields we're specifying about the body position at the time vital signs measured. It makes a difference for blood pressure too.

**Steven Lane – Sutter Health - Member**

I definitely do it for blood pressure. I'm just saying I've never seen it for length-height. I think it's relevant.

**Clem McDonald – National Library of Medicine - Member**

Well, it's not part of the field. The vitals have an additional question, which would apply to all of them that are in that package.

**Steven Lane – Sutter Health - Member**

Well, no. Each blood pressure, at least in my system, each blood pressure, you could specify if it was sitting, standing, lying down, etc. Again, I just don't think that's available for length-height. Again, I don't think it's a huge deal. It's just a matter that it could be called either one.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. A little bit more cleanup there, but we'll get to that. Then we're getting to additional recommendations. I think this slide pretty much with the addition of the compromise we'll rewrite. Okay. These are the three things – I'm sorry I didn't get HITAC to comment. So, we're going to comment.

So, if you go ahead one slide, if we take each of these separate, these are the three additional things. We will add the medication metadata. So, in provider demographics, was there anything else we wanted in how we described the provider?

**Clem McDonald – National Library of Medicine - Member**

Well, I don't think it's clear whether this is the provider as they exist or this is the provider in connection with the particular care episode. I think some of this yields –

**Steven Lane – Sutter Health - Member**

They should be mapped, right? Care episode, you sort of say who was involved. But then if you figuratively click on that person, this is the information you should be able to find out about them.

**Clem McDonald – National Library of Medicine - Member**

Kind of my point. Except at the meeting, there was the discussion that the role might have to be specific to the...

**Steven Lane – Sutter Health - Member**

To the encounter. That's fair. The role isn't just physician versus nurse practitioner. It's also attending versus consulting versus referring.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Yeah. You get some of that in the specialty training field to kind of know what your broad discipline is. I would say the role, it's almost a condition-specific mapping. What's my role? I'm taking care of the high blood pressure.

**Steven Lane – Sutter Health - Member**

That's a whole other concept, like what – I'd never thought about that. Good point, Terry.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

You have to have a care plan to the team members and the health concerns so that you can map the responsibility and outcome.

**Clem McDonald – National Library of Medicine - Member**

There's a challenge you make so the documentation – this may be even more work for the providers – they'll get their NPI in there automatically. So, I'm worried about expanding this.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Fair enough.

**Steven Lane – Sutter Health - Member**

So, Terry, when you talk about other demographics and using the term broadly, the other real use case here is in managing referrals. A provider or clinician is seeing a patient and they want to refer them to somebody else to deal with something. So, there's a lot more that goes into that besides just specialty and training. In the discussions that we've had over the years, having areas of special interest or expertise within a given specialty or sub-specialty, information about what languages are spoken can be really important when you're referring somebody.

Then there's the whole issue about access and their schedule and where there are openings and those sorts of things. That clearly goes beyond demographics, but there are probably some pieces in there that could be included. I think the language that's spoken is pretty important for that referral use case.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Interesting. I was thinking that other things that are on the list are often insurance is accepted. That's sort of an access issue.

**Clem McDonald – National Library of Medicine - Member**

I think we're getting into some complicated stuff. I don't know that we can figure that out at

the end of this process.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Good point, Clem. Where do we want to start? I think we make it clear that the role is for the episode of care and the specialty training is sort of –

**Clem McDonald – National Library of Medicine - Member**

I would even worry about that because there's an additional burden. You don't have to require all that now. It's kind of inferred usually.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Well, again, speaking to my experience with my EHR vendor, there are two lists for a patient's care team. There's the overarching static care team list and then there's a more dynamic, who's on the care team for this episode. Oftentimes, those will overlap, but they're going to be different. If someone's in the hospital, there could be a nurse. There could be a care manager. There could be a discharge planner. There can be a lot of people whose role is encounter-specific as opposed to kind of persistent at the patient level.

**Clem McDonald – National Library of Medicine - Member**

But that's still easy. All you have to do is put in NPIs and you have to do that anyways at the visit. I'm more worried about having to adjudicate between whether he was behaving as a blood pressure expert or as a counselor and all those things. I just wouldn't get into having to specialize all of those attributes by visit because of burden and how important is it really? Nobody's complaining about that right now.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

This list down, it would be name, contact information, NPI, and probably the general area of discipline.

**Clem McDonald – National Library of Medicine - Member**

The NPI has that in the database. It includes the name and the address, sometimes more than one, and their specialty.

**Steven Lane – Sutter Health - Member**

I think we've identified that contact information can be multiple response. A lot of people practice in more than one system, more than one location. They have multiple specialties.

**Clem McDonald – National Library of Medicine - Member**

That's true.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Maybe the contact information, that's fine. You put it in where you can be contacted.

**Steven Lane – Sutter Health - Member**

Even direct address or fax number. This is my direct address at Partners and this is my direct address at MGH and they're going to be different. Certainly fax numbers, same sort of thing.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

I think we're interested in fax numbers in the US.

**Steven Lane – Sutter Health - Member**

Kill the fax.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Although it will be part of the contact information, I'm sure. Then we can drop the expand in the future. I think that's sort of someday when we take on care plans, that will be something we want, but not right now. Okay, Clem?

**Clem McDonald – National Library of Medicine - Member**

Sounds good.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

All right. Here we go. Steven, you're on.

**Steven Lane – Sutter Health - Member**

Okay. That one. Sure. So, I'm involved in a California statewide HIE discussion initiative that has a lot of payers and providers trying to collaborate together. Clearly, there is repeatedly this discussion about the fact that we need to be sharing quality data, that payers need to send it to providers, providers need to send it to payers. We need to try and standardize that both in terms of the content payload as well as the various ways in which that data flows between those stakeholders. So, I just wanted to flag this.

One of the things that's been proposed by Jamie Ferguson from Kaiser in the context of this discussion is trying to do some pilots of a CCD-based transmission of standard quality metric data elements from providers to payers.

That's clearly something that all the payers want and everyone's trying to skin that cat using different knives but I think that we really should think about this in a transport-agnostic way, both from the FHIR perspective and the CCD perspective, to say there needs to be a standard way where you push a button in one system and it packages up all the standard quality metrics in a dynamic way and based on a dynamic list, which, of course, is always changing as CMS and other folks change their mind about what needs to be included.

There's a standard about the data level content and then there are multiple ways to package it, whether you're sending it V2 or CCD or FHIR and there's a common and expected capability of being able to transmit that and receive that and ingest it. That was all I wanted to share.



**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

It's a yes on that item. Let's break right there and go to public comment and hopefully we've got some of our folks still on the line who will step forward.

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

Thanks, Terry. I know we've had a lot of public comments in the chat feature so far. Operator, can we please open the public line?

**Operator**

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

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

Do we have anyone dialing in at this time?

**Operator**

Yes. Our first public comment comes from Robert McClure with MD Partners. Please proceed.

**Dr. Robert McClure – MD Partners**

Hi, folks. Just to give you the full information about what I put in there about a small item on the pediatrics. The idea of being able to share it if you've got it – so, if you've got a calculated percent, which would be based on weight, height, or whatever, against some data set, I spoke with LOINC [inaudible] [01:17:17] kind of worked out of a process. I don't have confirmation of this, but I suspect there will be a new observation.

I put that in chat as a proposed name for it, where if you were to submit or send one of the current observations, something like percent growth or percent height-weight, you would send that as you could now, but then you have something called an associated observation, which would be this new observation. That observation would have a set of proposed probably LOINC answers that would enumerate the known set of charts or data sets that are available on CDC's site.

You would then say, "Okay, then I'm going to be using the CDC girls' height-weight chart." That way, you'd be able to send the information. You can also identify what it's actually a percent based on comparison to what data set. That, I assume, would be available perhaps even as early as the next release at LOINC.

**Clem McDonald – National Library of Medicine - Member**

Sounds like a good idea. How did you get there?

**Steven Lane – Sutter Health - Member**

Right. There are other data sets where this sort of thing could be used. It's not tied to specific. It's a general observation. So, you could perhaps find other places where this would be useful.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

That's great. Thank you so much for slogging away on the chat. We really appreciate your thoughts.

**Dr. Robert McClure – MD Partners**

No problem.

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

Thank you, Dr. McClure. Operator, do we have any other comments in the queue?

**Operator**

There are no other comments at this time.

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

Okay. I will turn it back over to Terry.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. So, let's go back to where we were. So, the discussion about a standardized clear response, in a sense, it's a document type, I suppose, but it's something different. The whole area of quality measurement has not come up for discussion the way it should. Any thoughts on how we make this stronger?

**Steven Lane – Sutter Health - Member**

As we were saying, we need to think about the payload. Who is going to be responsible for specifying what is the standard data, whether it's a query or response to standardized quality metrics? There are going to be standardized quality metrics and probably some non-standard quality metrics that are relevant in some specific domain. Somebody needs to create and maintain that catalog.

For each of those metrics, there needs to be the specification and we need to know how to package that up and send it via FHIR and how to package that up and send it via CCD or V2 or whatever is coming in the future. We need to figure out what's the right lever from a policy standpoint to require that. Is that going to be on CMS or ONC or CCD, CDC, or somebody else? So, I think those are the components we need to think through.

**Clem McDonald – National Library of Medicine - Member**

Steve, can you help me? This is something that now is required for some quality metrics. Are you talking about generalizing it to any quality metric or doing it in a different way? That's part of the spec now, isn't it? All that stuff they're doing in meaningful use for the last four or five years.

**Steven Lane – Sutter Health - Member**

What I sense is – this isn't my area of deep expertise – people are doing it all differently. It's like you've got to send your quality metrics. The providers have to send them to the payers. The payers have to send them to CMS or wherever they send them. But some people are doing it with data extract. Some are doing it with interfaces. Some are extracting it out of received CCD documents. I sense that it's kind of all over the map and people are bootstrapping this. I think the idea is to make this more standardized and more stands-based.

**Clem McDonald – National Library of Medicine - Member**

My understanding is that the ones in Medicare requires people do them that way somehow. I don't know more than that. Also, the insurance companies have different ones. So, there's a different rule. There are issues about the different rule versus the different way of shipping, I think is what we're talking about.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

The payload, Clem, is different depending on who's asking for it. You've got HEDIS. You've got NQF, non-NQF CMS measures. There are lots of different things. I think we should be able to get to a standardized payload that starts up there with numerator-denominator exclusions and then what you're looking at.

**Clem McDonald – National Library of Medicine - Member**

How far away from having a standard definition versus a standard everybody doing it the same? I know they all do it the same. How can we make everyone to do it with the same rules, the same purpose? You can be using the same rules and it still comes out looking different, but a lot of them are doing different rules.

**Steven Lane – Sutter Health - Member**

I think you're right. I think different systems, payers, etc. have evolved. Again, there's a group called the National Quality Forum that I'm sure could tell us a lot about this. It doesn't sound like any of us are an expert. I certainly hear in my organization, we get queries from left, right, and center for sending in quality data. I know that we have teams that work on that. What I've heard from them repeatedly is each request is a little different and they want it using different methodologies. I think the goal here is to try to standardize that and then include in USCDI those pieces so that they should all be interoperable and required.

**Clem McDonald – National Library of Medicine - Member**

Is it mostly a matter of herding the payers and those various cats or is it a matter of defining a technical standard?

**Steven Lane – Sutter Health - Member**

Probably both.

**Clem McDonald – National Library of Medicine - Member**

I think Hooks and CQL will turn into pretty good technical standards. I wish Ken was on the call because he probably knows a lot about it.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Dr. McClure has got a couple of comments in the chat. To answer, no PHI, this usually is all deidentified.

**Steven Lane – Sutter Health - Member**

Yes and no. The reporting part of it is deidentified, but there are a whole process and workflow where individual providers and payers have this dialog about trying to close care gaps for individual patients to optimize the quality of the care and the reporting of the metrics. So, I think there's both. There are patient-specific data that relates to the metrics and the care gaps themselves and then there is collective data for a population of patients.

**Clem McDonald – National Library of Medicine - Member**

Robert McClure, his QRDA III, that's where I saw it existed, something like that. It would take care of the shipping. Is it true that it's not meant by that now? Are we not that standard? I understand that everyone may have different rules cooked into their spec, but no one's using QRDA, right?

**Steven Lane – Sutter Health - Member**

So, as part of our certification program at ONC, we have testing for electronic health records systems to be able to ingest and produce QRDA files based on the CMS specific released annually. I put a link to the site there.

**Clem McDonald – National Library of Medicine - Member**

It sounds like we want to propose all quality users use the same thing to ship it and then there's a separate problem about the quality users using the same rules to generate the QRDA.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

We're running out of time in two minutes. Is this item already in existence with the QRDA? There is a standardized format. Is that something we can build on rather than propose something new and different?

**Clem McDonald – National Library of Medicine - Member**

It sounds like John Bender just gave us the link to it.

**Steven Lane – Sutter Health - Member**

I would say yes.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

So, how to phrase this – again, getting a standardized quality reporting process makes a lot of sense. Maybe we just say we recommend building on QRDA, expanding it to multiple...

**Clem McDonald – National Library of Medicine - Member**

I would suggest a two-part thing. One is finding a way to require quality reporting people to use QRDA as the packaging. The second thing is trying to find a way – they don't all have site variations under rules that generate those packages. I know they do.

**Steven Lane – Sutter Health - Member**

Terry, you know how in our ISPTF we have brought in subject matter experts to educate us about things? It seems like QRDA is one of those things that USCDI should get educated about.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

I think for the purpose of transmittal letter we'll try to wordsmith this and build on what already exists rather than propose something new. For our phase two, as a group what we're going to do is the data element, data class advancement process, this would fit nicely into that. How do we move standards through? How do we move other things? Next week, we're going to go through our transmittal letter, vote on it, hopefully finalize it, and then Steve Posnack is going to give us a head's up about what phase two is going to look like.

**Clem McDonald – National Library of Medicine - Member**

The QRDA, they now for CMS have to conform to it. It might be these other players who aren't reporting to CMS that are the renegades.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Okay. Do you have any proposed language?

**Clem McDonald – National Library of Medicine - Member**

I think we should find to encourage all those that look for quality reports to number one, use QRDA or make changes that make it possible they can use it, and then secondly is that there would be some central area that would coordinate the variations and rules and try to reduce them so the hospitals don't have to do it differently for everybody.

**Steven Lane – Sutter Health - Member**

This sounds a lot like what CMS has baked into their proposed rule. Just like they were saying, "We use Blue Button to allow patients to download X, Y, and Z. We want all the payers to do the same thing," CMS says, "We use QRDA for standardized quality reporting. We're going to require all the other payers that we have any authority over to do the same and encourage the industry to go in that direction. It's very similar.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

That sounds perfect.

**Steven Lane – Sutter Health - Member**

Of course, we're not providing input to CMS at the moment, but we can provide something like that into the USCDI recommendations to ONC.

**Clem McDonald – National Library of Medicine - Member**

It's not unreasonable. How are we doing, Terry?

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

We're done. I think we're okay. We'll get a transmittal letter out for us to review shortly.

**Clem McDonald – National Library of Medicine - Member**

Good. Thank you for all your hard work.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Thanks, guys. Good session today. Thank you to all the public commenters, really appreciate the input. More to come. We'll get together on Monday.

**Sheryl Turney – Anthem Blue Cross Blue Shield - Member**

Thanks, Terry.

**Terrence O'Malley – Massachusetts General Hospital - Co-Chair**

Thanks. Bye.