U.S. Core Data for Interoperability Task Force

Transcript
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Virtual Meeting

Speakers

Name	Organization	Title
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
Sasha TerMaat	Epic	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Adam Wong	Office of the National Coordinator	Back up/ Support
Al Taylor	Office of the National Coordinator	Staff Lead
Johnny Bender	Office of the National Coordinator	SME

Operator
All lines are now bridged.

Cassandra Hadley - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you. Good afternoon, everyone and welcome to the USCDI task force meeting. Today, they will continue their discussion on the promotional model. With us, we have the co-chairs, Christina Caraballo, Terrence O'Malley, and we also have members, Sheryl Turney and Tina Esposito. Am I missing any other members who are on the line?

Steven Lane - Sutter Health - Member
Steven Lane is here.

Cassandra Hadley - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Steven, thank you. Anybody else? All right. Christina.

Christina Caraballo - Audacious Inquiry - Co-Chair
Great. Hi, everyone. Thanks for joining on a Friday afternoon. I guess we can go ahead right into the next slide. Just a recap of our charge looking at the data promotion life cycle. We are going to jump right back into our Google document today. And we have some updates in there that we've all been working on. Adam, if you want to go ahead and pull that up while we're talking, it can kind of start to give an introduction. One of the things that Terry and I were discussing this week was the amount of work we did last year on this task force. So, in the appendix of the slides that were sent around today, we actually included last year's recommendations on the progression through USCDI as we saw the data element move. ONC has changed the number of stages.

We had suggested six so we actually are in agreement that this more simplified approach is good. That said, we did spend a significant amount of time going through the process and things that we thought were important. So, we have as kind of something we did yesterday added that to the slides that were sent out as a reference. I don't know that we're going to be pulling them up but I think they're a good read through for the full task force to go through. And we can definitely bring them up should we want to at any stages. Before we jump in, I just want to give a quick update on where we are with the Google document.

We have begun to take all of the notes from the task force and change them into just draft recommendations by putting them into recommendations instead of just notes and putting them in their areas within the document is going to help us direct our conversation a little better and start seeing what we agree and disagree on as a full task force based on what we've come up with so far. Adam, I see your Google doc off to the right but it's not being shared in the main screen yet. Perfect. So, Terry, before we kind of kick in, is there anything else that you wanted to add?

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

No. Just – well, yeah. So, reading the slides from last year, it really looks like ONC dropped Stage 6, which makes sense because that was sort of universal adoption. And that's really what USCDI is. So, we lost Stage 6, which was no loss. And then, they kind of combined Stages 1 and 2. So, I think we're pretty well ahead in terms of our thinking. And I think we just have to sync up what we wrote last year with the current draft and make sure that it's got all of the things we thought were important. But I think we did most of the work last year, which is nice. If someone thinks otherwise, we'll spend more time. Anyway, that's all I wanted to say. I think we're in better shape than we thought we were. So, with that, jump in.

Christina Caraballo - Audacious Inquiry - Co-Chair
Okay.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
And Christina, when are we going to do an update to the HITAC?

Christina Caraballo - Audacious Inquiry - Co-Chair
Oh, right. Was it July 11, the next HITAC meeting?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah.

Christina Caraballo - Audacious Inquiry - Co-Chair
ONC team, is that July 11? That's just off the top of my head.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Okay. Yeah. So, whatever we talk about today, we will roll into an update presentation for the HITAC on the 11th. So, if you have anything you really want to pass on to the HITAC, speak up.

Christina Caraballo - Audacious Inquiry - Co-Chair
Yes. And if you're coming into the Google document, to add onto what Terry just said, please feel free in the suggestion mode to put in recommendations instead of just dialogues where they belong in the sections because I think that will help us just move along in this process a little more efficiently. We don't have to translate either. Okay. So, shall we go into just some – I think we should actually start with some general discussion and overarching themes because we were able to pull out some things just in the dialogue throughout the Google doc and actually put some recommendations up here in the top that we haven't discussed as a group. So, Adam, I think if you can scroll down just a little bit to the first one, perfect. And pause here. I'll let everybody take a moment to read the first one.

So, this is, basically, in summary going beyond as classifying a data element and create a model in which ONC and federal government facilitate and actively promote data elements through the process. We're really looking at ensuring that the public good data elements that are identified and attention is given to them with the appropriate champion. The top three are kind of tied together. We might end up consolidating but next is based on requirements

blurring the health system. There's a role for ONC to play in identifying the priority data elements that are a critical gap. And not just taking a passive. Let the market determine what is sufficient. And then, the third kind of ties these two ideas together. And we've proposed through our conversations of having ONC convene on authority such as a USCDI technical evaluation body.

This is in magenta because we still need to think about what that right word is for that. We originally had it as a committee. But in talking and thinking it through, our current train of thought is that we have this technical evaluation body live under the HITAC similar to the USCDI task force. But it's specifically focused on data elements and data classes going through the USCDI process from the very beginning of identifying what those high data elements/classes are all the way to actually being a part of the USCDI. One of the things that we were thinking about under this task force is that it would live again under the HITAC. But we think it's really important that members outside of the HITAC are a part of this. So, part of our recommendation to ONC would be specifically to have additional stakeholders.

And we do think that we should define those stakeholders. So, we've started to generate some examples of government agencies that should be represented and others. And I would like to kind of think through that list as a group as well. One of the ideas behind this is to really create a place for industry to come together and have collaborative dialogue and conversations about what we should focus on across multiple stakeholders for core data nationwide. So, I'm going to pause there since this is kind of a new – not a new idea but a little more thought through and open it up for discussion.

Steven Lane - Sutter Health - Member
And there's an anonymous iguana out there throwing potshots at your text, too.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
That's Sasha. So, welcome, Sasha.

Steven Lane - Sutter Health - Member
Actually, I think I'm the anonymous iguana.

Sasha TerMaat - Epic - Member
I was going to say I don't think that's me.

Steven Lane - Sutter Health - Member
I don't mind giving Sasha the blame for stuff that I do – no, I'll take it.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
You are. You're the anonymous iguana. All right. You better be careful. I think they're going extinct, at least the anonymous ones.

Steven Lane - Sutter Health – Member

That's why they're staying anonymous, right?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
That's right. So, this is kind of somewhat of a new concept. And it's not so much the data per function model per se but it's to add another – I guess it is. It's to add another arm in the process. And then, we can talk about whether we think that is an unnecessary complication or whether it fills a role.

Christina Caraballo - Audacious Inquiry - Co-Chair
And to that, as we've gone through the recommendations and looked at the last section on this is HITAC full and in USCDI and then, moving through the different stages, we tried to start to incorporate this concept of the technical evaluation body and the role they would play in each level. As you move through the Google doc, you'll start to kind of see that. We'd love initial thoughts on the role of this group and if people think it's a good idea.

Tina Esposito - Advocate Aurora Health - Member
This is Tina. I think a high level of – I certainly like the sense of bringing folks that might have some depth in various subjects together to help guide recommendations. I think as you outlined, it's another arm. And this might be too premature but is there an opportunity to understand how those arms sort of work together? You were saying it's under the HITAC. And we're saying that we would also want to make this also market driven. So, how does that all come together? And if it's too soon, that's okay. I know this is a recommendation. But that would just be my question.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah. It's kind of two questions. I think one is do we want it and the second is if we do, what does it do. And then, who is on it? And then, four is probably how do they get there.

Tina Esposito - Advocate Aurora Health - Member
How does it sort of work together? I think the challenge with creating another layer is that. How do you ensure that it's beneficial and it helps guide the other layers or provide input that may not have been available otherwise?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
One of the striking issues, I think, that exists is the federal government is not terribly well organized about its use of data and data standards. And so, one of the potential roles of this group would be to get government stakeholders around the same table to identify priority data standards and data element, data classes. So, that was one of the reasons I thought this was valuable.

Steven Lane - Sutter Health - Member
I think that's a valuable reason. I'm surprised to see DODVA listed here because I think of their interest as being kind of generically clinical. Was there something special about military medicine that we thought needed to have a voice here?

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

Just that they're big.

Clem McDonald - National Library of Medicine - Member

So, this is Clem.

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

Hey, Clem.

Clem McDonald - National Library of Medicine - Member

I don't like the idea that we don't know what it really is. That part makes all of the difference in the world. It's going to be some other stakeholders that are not totally specified.

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

And Clem, do you think if you were to have such a group, who do you think ought to be around the table or do you think there shouldn't be a table and somebody else should be present?

Clem McDonald - National Library of Medicine - Member

I do worry about the complexity. But it really depends on that once you open it up, will it stay that group? And what will be the interaction? Will it just slow things down? I just don't know. If you had a definitive proposal with these organizations, it would be easier to respond to.

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

So, you would say make it as a proposal. Invite these entities to participate and see if there's a response?

Clem McDonald - National Library of Medicine - Member

No. We're saying we should have this other layer and then, tell them **[inaudible] [00:15:45]**. And we're going to invite some people that we don't know who they are and do you like it or not. That's my understanding.

Christina Caraballo - Audacious Inquiry - Co-Chair

Yeah. So, we originally had this as an advisory committee standalone. And I think, Clem, some of your concerns were vocalized to us. But one of the roles of the HITAC, even in this promotion model, is going to be to look at the data elements coming through the USCDI promotion model. So, having this advisory committee, even if we don't have everybody but we can start to generate momentum and bring in the right people is going to also help inform the HITAC to be able to have the right kind of stakeholders to weigh in. So, I think having a –

Clem McDonald - National Library of Medicine - Member

I'm not talking against having advice. I'm just worried that it could be – commercial companies might want to get in. They may be good enough. But it's just going to change this – without knowing what we're talking about, it's hard for me to respond. That's all.

Steven Lane - Sutter Health - Member

And maybe I can chime in because I think I was part of the group that suggested this in the first place. And, again, I think it is going to be up to HITAC to review items as they come forward and determine where they slot and how they move forward. When I first thought about this group, this committee or what we're calling the technical evaluation body, again, the best term that comes to mind is affirmative action. The idea that there are going to be data classes and data elements that may not have a powerful constituency to push them through the standard process. And my thought was that there just needed to be a body that could provide advocacy and support for those other things, which, again, I think, as you said, military, they're big, they're important. But, again, I have a hard time thinking about how they might have data needs that are unique to their situation. Maybe they do.

I haven't worked in the military for a long time. But clearly, NIH has research needs that aren't going to necessarily be backed by powerful, vocal constituencies. FDA, I don't know but I think about, again, those groups. SSA comes to mind where they're talking about things that impact the disabled that maybe won't have a strong constituency. So, that was my thought is that this was a group that had a pretty unique role. It wasn't the overall evaluation of proposals the way that HITAC is. It was a different role.

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

I think the other concern, Clem, that I had is that we had pretty much a market-driven process. Now, if you get to the front of the line and you've done all of the work and you've pushed the two standards and you got it into production, somebody has done that. And it's not necessarily done in any sort of strategic fashion or within any grand view of reaching the triple, quadruple aim. It's done because some large market segment has organized it. And I'm not sure that that serves the country well and whether – and I think we would all benefit from a little bit more strategic view recognizing there's a tradeoff because the market may not like the strategic view and do nothing about it. But I don't know what the balance is between those two.

Clem McDonald - National Library of Medicine - Member

Well, the other thing is the market is really a wise force. And it is not as subject to small, loud voices that may or may not know what's what. I don't think it's a bad voice but I think other voices might be appropriate but we just haven't clearly named them. And I don't want to vote for a ballot where I don't know who is on the ballot.

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

That's part of our discussion is maybe we should figure out if we –

Clem McDonald - National Library of Medicine - Member

I mean, it's groups like you could think of HIIM or you could think of the HL7 vocabulary group could be very related and also in terms of being a mixture of – well, mostly probably industry. But there are a lot of categories that can dream up and who might be good, might be contenders. It's just that it's a pig in a poke right now.

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

So, to your suggestion on HL7 or some other STOs, my sense is that they would definitely have a seat at this table. And you may even put Regan Street at the table. If you really want to get a group that's informed about what data classes still have holes in them but are broadly applicable, we might want to think about who ought to be around the table on that. It's something to –

[Crosstalk]

Clem McDonald - National Library of Medicine - Member

Yeah. Well, I just don't know. But I think we've got to get somebody to cook up a list of the kind of people. It's the kind of groups. NIH might make sense but NIH is at the top, I don't want to be critical of NIH, is necessarily knowledgeable about all of the pieces and parts below and whether to be the research community, not NIH. There are a lot of choices you could make, even in that context about the researchers. CTSA is the group of all of the universities. It's an odd group but it's supported by NIH and it should be them or NIH that would be represented. I'm open to all of it. I'm just not the one thinking. I don't know what's going to happen if we don't make some choices and then, put up for a decision.

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

Would it help if we thought more about what this body would do and what our expectations of this group would be?

Sherly Turney - Anthem Blue Cross Blue Shield - Member

That would be good.

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

Maybe make a list of those and then, figure out who can do it.

Clem McDonald - National Library of Medicine - Member

Well, no one else is talking much so in that sense, I don't have a sense of whether there were any other people that are worrying or have my concerns.

Tina Esposito - Advocate Aurora Health - Member

This is Tina. I would agree. I think form follows function. So, if we define what we feel is the gap, and I think Steve articulated that then, we can probably identify who else may need to be at the table. But I think identifying what we think would be the function of the group because we feel it has to be represented or it better identifies areas that need to be addressed, I think is very helpful.

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

Maybe part of the function is affirmative action for strategic data value. That someone is thinking ahead about what data needs may or may not be being addressed.

Clem McDonald - National Library of Medicine - Member

The other dimension of this is are we going to push for technical abilities to open up data that's sitting there? Or are we going to ask commissions and others to collect data that are being collected now? And I'm sure this data is needed but they're different pluses and minuses about those two different approaches.

Steven Lane - Sutter Health - Member

Terry, what you said just triggered an idea for me, which is that there may be a role, not only of advocating new data classes or elements all the way through the process that don't have a constituency but also in reaching out to constituencies that haven't thought of something on their own. When you say strategic, where should this be going? We need to put in A, B, and C if we're going to be able to, in the future, get to X, Y, and Z. So, there could be kind of an advocacy that simply kind of jump starts the market-driven process or supports it or guides it. Just a slight variation there.

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

Right. Advocacy is a good group. But Clem, you're probably most knowledgeable about what sort of data tracks there are within the government. And is there any overall coordination of what's going on? Explain to me how it gets done. It seems to me to be a free for all.

Clem McDonald - National Library of Medicine - Member

I was on mute. So, there is a new activity that's trying to coordinate health IT planning across the government that's brand new. And in NIH, there are strategic plans but it hadn't historically been very tied to health data. But they are getting very, very interested in that as of this month. You'll see some stuff coming out probably in the next month or so. But they're starting to recognize the value of health data through their research endeavor, especially medical record data. So, they'll be interested. And they're not going to be quiet once they get cranked up. So, on the one hand, I think they're very important and there are different research needs that wouldn't necessarily come up with us otherwise. But I think they will articulate it through and push it as sort of a waking giant now about health data. But in general, there's work to be done in unifying all across a lot of places.

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

Beyond that, are you aware of any sort of coordinating activities? You would think the Office of the National Coordinator would have something to do with that.

Clem McDonald - National Library of Medicine - Member

Well, actually, they're part of this newly emergent government health IT strategic plan development is what it really is. And they, I think, are actually leading it. And they met two weeks ago, I think, for the first time. So, it's cooking but it's nothing done. And I keep coming back to –

Steven Lane - Sutter Health - Member

What's this group called again?

Clem McDonald - National Library of Medicine - Member

I think it's called the federal health IT strategic planning committee. Something like that. But someone from ONC may know better. It turns into an acronym and I'm just drowning in acronyms. I don't keep them straight anymore.

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

So, maybe that's the committee that ought to just plug into this slot.

Clem McDonald - National Library of Medicine - Member

Yeah.

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

Or that committee plus some add ons.

Clem McDonald - National Library of Medicine - Member

Well, that committee will assert something no matter what because it's going to be all of the government agencies. I think those related to health data and healthcare.

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

So, maybe it's already being done. And if that train is certain to leave the station –

Clem McDonald - National Library of Medicine - Member

Yeah. Something will happen.

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

So, for the rest of the group, what if we – this is a place holder for a group just like that.

Clem McDonald - National Library of Medicine - Member

And then, maybe we should wait at least a couple of months and see how they evolve. It may be actually quite accurate in doing things in that period of time and deciding things.

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

And you would think that they would want a pathway into ISP and USCDI and certification and maintenance.

Clem McDonald - National Library of Medicine - Member

Yeah. I'm sure they would. I'm sure they would.

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

So, this would be a way to just get plugged into that whole process.

Clem McDonald - National Library of Medicine - Member

I can maybe dig up their official name if you need it.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
My sense is we need something like that. And if someone else is already building it, that's part of the issue. I'm not sure they'll get to Steven's point about affirmative action for data elements or classes that aren't necessarily being broadly pushed in the market.

Clem McDonald - National Library of Medicine - Member
Okay. I think I have the name here once it pops up. It's the Federal Health ID Coordinating Council – no. I'm sorry. I misstated a little bit. So, there is a Federal Health ID Coordinating Council. And they are starting to develop a federal health ID strategic plan. And ONC is sort of in the center of that.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Then, maybe our recommendation is pulling that group into this process and you figure it out.

Clem McDonald - National Library of Medicine - Member
That would be a reasonable thing.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
And I'm sure there are – Al, I'm sure you are already thinking about how that can be done.

Al Taylor - Office of the National Coordinator for Health Information Technology - Staff Lead
Yeah. The first thing that comes to mind as you're talking about this, I think the difference is this mostly federal group that might be chiming in on USCDI and on other health IT stakeholder work groups that might actually be the shepherds of some of these data classes.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah. That certainly addresses one of my use cases was that you would think they should have a strategic plan within the government and that somebody ought to be thinking about what's needed and think ahead about what data classes are going to be needed to drive it. What's currently being proposed sounds like it addresses that perfectly and completely and doesn't need to be duplicated anywhere like if it leaves us with Steven's affirmative action group.

Clem McDonald - National Library of Medicine - Member
So, Steven do you have specific ideas again that we could know what the pig is in the poke?

Steven Lane - Sutter Health - Member
Well, again, I don't have specific ideas. I'm just thinking about data classes and elements that won't have a natural constituency to advocate for them in the market where they just need some help. And the truth is that the market is very diverse and includes folks who are not

motivated purely by financial gain and are really trying to do the right thing. The whole social determinants group and public health and research. But some of those folks are all really busy and working at a not for profit space and just may not have the voice to compete with commercial interests. So, that was really just my thought was just that there are stakeholder groups in communities that might not get heard or might not be able to negotiate the whole process of getting into connectithons and getting into pilots and everything else.

There's really just a sense of sort of a maternalistic body that could help out where people need that.

Clem McDonald - National Library of Medicine - Member
You know, if you wanted to pick a group that might be in that category, it might be the safety net hospitals and their clinics and that sort of thing.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
And along those lines, think a little broader. So, who is providing healthcare that's not really in the healthcare system? And two things come to mind, schools and prisons. So, who is advocating? They do a lot of healthcare. They're just not recognized as such.

Clem McDonald - National Library of Medicine - Member
Yeah.

Tina Esposito - Advocate Aurora Health - Member
I think in all of those groups, you'll also have just the highlight of the consumer and what's the most important information for the patient to have and the broader care teams that coordinate and care for those patients. Whether in the safety nets of schools, the prisons, there's got to be common data that would be really helpful to all of those groups in that centralized –

[Crosstalk]

Clem McDonald - National Library of Medicine - Member
There are known challenges. And in the prisons, its privacy is different and tighter. And then, that would become important in the TEFCA sort of thinking. Can they get the data moved, get it moved and how do you have it moved? It might be true in schools, too, because the kids each have special kinds of protections, too.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah. It's a different data privacy rule.

Clem McDonald - National Library of Medicine - Member
I don't know if the data would be as different as the movement and how you get it to move and what are the special problems. It would be different for sure.

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

And Clem, you make a good point. Before we get wildly exuberant, we should really continue to focus on data elements and classes. That's our job, not to integrate all of healthcare. So, point well taken.

Clem McDonald - National Library of Medicine - Member

I wasn't trying to make that point but I'm glad I did. The way you said it makes sense.

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

So, have we come to any conclusion out of this? Or let me state maybe three conclusions. 1) There's a need for a government based strategic IT body to provide input to HITAC. 2) There's a need for a body to promote, encourage support, the creation of data elements and classes for parts of the healthcare system that don't have perhaps the resources or the knowledge to push them along this really arduous USCDI pathway. And anything else or just those two? And the dates, you always say there are three points I want to make and you hope you come up with the third one by the time you get through the first two. I got to two and then, I ran out. We'll just leave it at that.

Clem McDonald - National Library of Medicine - Member

That's all you got.

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

All right. Okay.

Clem McDonald - National Library of Medicine - Member

While there's a lull, Steven, you talked about one of the meetings we're going to talk about, the NCPDP specification. Is that formed yet?

Steven Lane - Sutter Health - Member

That's in the other task force. That's ISP.

Clem McDonald - National Library of Medicine - Member

Okay. Thank you for exposing that and getting that out. You pounded on them and it came out.

Steven Lane - Sutter Health - Member

They were very cooperative.

Clem McDonald - National Library of Medicine - Member

Yeah.

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

Does anybody want to share with the group on the AMA?

Steven Lane - Sutter Health - Member
Sure. I'm happy to do that. Is this the time and the place?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah. Just as an FYI to let folks know what else is cooking in the background.

Steven Lane - Sutter Health - Member
Yeah. So, Terry and Christina and I and some others had a meeting with some folks from what's that arm of the AMA called? I'll figure it out. They've got an acronym. Integrated Health Model Initiative. The IHMI. And they are working on health data models. And we had a proposal bubble up through the interoperability standards priorities task force in part stimulated by discussions we were having around closed loop referrals and the standards to support them.

And the idea was that we felt that there needed to be standards around the clinical data. That is to say the clinical content that should ideally be collected prior to making a referral between specified medical specialties or care settings, the idea being that a lot of the referrals that we make are just kind of populated organically with the data that happens to be there but that many of us who have been in practice know that if you're sending someone to a cardiologist for heart failure that they probably would like to have an echocardiogram and an injection fraction done first. And maybe they'd like to have some other things. And if you're sending someone to an ENT doctor for thyroid mass that there are certain things that they might want with regard to TFTs or an ultrasound, etc. So, and this has all kind of been done organically that some organizations like ours have developed service level agreements and agreements driven by individual specialty departments or providers.

But the idea was if we could do this nationally, if we could bring together specialty organizations to say this is what the endocrinologists want, this is what the neurosurgeons want, and this is what the dermatologists want, when people are being referred for the whatever top five, ten reasons why people are referred that that could streamline the referral process. We could then, bake in decision support to help to refer clinicians to collect the data or to pull the data as perhaps Fyre data elements out of their EHR and send it along through standard interoperability. So, it was a great idea but we didn't know where it was going to live, who was prepared to take that on until we reached out to the integrated health model initiative group at the AMA and had a bit of back and forth. And they eventually said yeah, we think this is a great idea.

We'd love to take it on. And that back and forth took about nine months. And now, we're fourth. And they are enthusiastic about doing this. And they really see it as needing to align with USCDI because as they generate, for example, they might start with I think we talked about cardiology because the American College of Cardiology was interested. So, when you have some example of when primary care sends a patient to a cardiologist for heart failure, what would be that data? And then, they would sort of put that all together working with primary care organizations and cardiology organizations, etc. And then, their thought is that would come back through USCDI and that the data elements that were required to populate

these referrals would be progressively added to USCDI. That's sort of the big picture. And Terry, did you want to add to that?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
No. But it's related to USCDI. And I guess the question I would have is do we see this – Steven, do you see this as a thousand different data sets? Or do you see it as a standard based almost like a CCDA type organization where we take standard data elements, clinical data elements, and just repackage them into different groups?

Steven Lane - Sutter Health - Member
Yeah. I think it's more the latter and whether it ends up moving by CCDA or Fyre or what have you isn't really the point. But at the USCDI level, a lot of this is going to be clinical notes and vital signs and labs and things that are already in USCDI. But some of it is going to be novel like the ejection fraction is a classic one that people talk about. I don't think that's in USCDI yet. It probably needs to be, especially if we're going to be talking about referrals to cardiologists. Specific data related to cardiovascular testing like, for example, the Coronary Calcium Agatston Score. I don't think that's in USCDI yet. Is that a lab test? Not really. It's not just an imaging study. It's a discrete data element that at some point we're going to have to say this is important. And systems need to be able to move that. People joke sometimes I think about handedness.

Well, if you're referring to a plastic or a hand surgeon, handedness really does matter. And maybe, I don't know, but maybe they would say we really want that as discrete data and the Epics and the Cerners of the world and the USCDI will need to cope with that. So, I think it's going to be more kind of these one-offs like dermatologists might want – there is some skin classification system that I don't personally use in my practice but they use. And maybe they're going to say we really want PCPs to determine the skin class before they send us patients for skin cancer evaluation. So, again, I don't think it's going to be thousands of things but it might end up being 100 things when you work your way through all of the clinical specialties and all of the classes of caregivers because, again, the AMA is going to have a physician bias. But the same thing.

It's like what do chiropractors want if they're getting a patient or what do – you can just go down the list. What do home physical therapists need? Is there something about angles of joint range of motion that rheumatologists are really going to want? So, I think over time, this will be a pipeline for new data classes and data elements.

Clem McDonald - National Library of Medicine - Member
Steve, I think most of the things you mentioned we should just ask for them and not wait for anything. The ejection fraction Terry and I have talked about and Ken Kawamoto. We talked about it for a while. But the question is how would this work? Who owns what? What's the collaboration? What are the alternatives for doing this and do this subspecialist where you want to play through the AMA?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Hopefully, that's the AMA's problem. Hopefully, they do.

Clem McDonald - National Library of Medicine - Member

Well, the history is not so. The cardiology groups are pretty independent. I think that should be laid out. We should understand the game before we play it.

Steven Lane - Sutter Health - Member

And, again, I don't think we're saying this would be the only way this could be done. If the cardiologists want to do their own thing and come forward and propose the ejection fraction, that's great. But it hasn't happened yet. And at least in talking to the AMA, they say that they've got a working relationship with the American College of Cardiology and with the American Academy of Family Physicians and the American College of Physicians. And that's sort of where they were going to start.

Clem McDonald - National Library of Medicine - Member

Well, have we clarified the property rights, the –

Steven Lane - Sutter Health - Member

Yeah. They said they'd give it away. We asked them. We pushed them on that.

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

Okay. So, it raises the question in my mind about what goes into USCDI. And USCDI, ultimately, will be a compendium of data elements that can be re-aggregated into data classes because there will be similar data elements in different data classes is my thought. So, if we keep the USCDI on the level of the data elements and when anyone comes and pushes their data set through the process that just becomes data that anyone can use and it's already in there. And so, if their data set is made up of elements that are new to USCDI but many which are already in USCDI then, they don't have to redo the ones that are already in there. I don't know if that's clear but does that make sense?

Clem McDonald - National Library of Medicine - Member

Well, all of the terms you've mentioned, including the angle are already in a database. It's just that USCDI hasn't decided to accept them. And I think we could just make a massive request for a bunch of these things that are quite obvious. Ejection fraction is part of every decision rule about heart failure and its treatment. I know Ken is in Japan so he can't weigh in. I don't think he's on the call anyway.

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

Let me toss this out to Sasha because I think the balancing measure is what this means to industry to implement what are going to be conditions of participation or certification. So, Sasha, the commissions want everything in all at once.

Sasha TerMaat - Epic - Member

Well, they don't want to populate it all immediately.

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

Right. Well, they'd be happy to have it sooner rather than later. So, how much do we have to balance against the lead time for getting this in? Standards that already exist but aren't necessarily in production or available for exchange now. Getting a sense of the lift required to move them.

Sasha TerMaat - Epic - Member

I don't think it's something that can be generalized.

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

Yeah. I was afraid of that.

Sasha TerMaat - Epic - Member

So, we have to think of several different factors. One factor would be the standards themselves because inclusion in USCDI just identifies specific types of data. But there might be one or multiple underlying standards to implement that, whether it's a Fyre API or a CCDA template or an HL7 message. And those standards might have their own timelines, which would impact how you might want to implement them. If there's an updated version coming out soon that could influence implementation timelines. If the implementation guide isn't available yet, obviously, that would also be a factor we'd be evaluating here and looking at. Then, I guess, there's a factor of the scope of a particular health IT product and whether the data capture makes sense for that group of users and how they would prioritize having that feature in comparison to other things that they've asked for.

And then, once the data is being captured in at least some of the systems, how is it exchanged with users of other systems using some of those interoperability standards? Each of the products that would be exchanging would have their own set of development timelines. And so, if one product says we start our planning cycle every January and then, take prioritization at that point in time that might influence how they're able to deploy versus if another product uses another method. And so, if they've already made investments in a certain standard and a certain type of data capture, it might be a short time period to deploy that. But if they haven't yet made investments in the standard that underlies the data class we're talking about or in data capture in a structured way for that data element, it might take months or years to deploy depending on the complexity of what's being discussed.

That also turns into roles for the health system in terms of there are different ways in which health systems take updates to their software, whether it's upgrading the software that they use or applying an update to it in another fashion. And they have different schedules for how they take those as updates as they become available. And so, I don't know that I can generically say how much time is enough time. Each project would have to be evaluated probably by each health IT system to say how much time would it take us given the nature of what we do, how much we've already invested in the applicable standards and types of data, and the other priorities that we have on our docket.

Clem McDonald - National Library of Medicine - Member

This is Clem. I think it's simpler than that. I think you have two categories of data that you might be talking about. And I think if we as a committee went through all of these standard sort of ideal process rules, we could find them. So, some of the stuff like angles of the joints, that's going to be manually entered. There is no other way to do it. The ejection fraction could be manually entered or it could be pulled from a cardiac echo report. That would be a little more complicated. But all of the systems have the ability to pick a form and stick data in. So, I don't see new product development to do most of these things.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
So, you're saying, Clem, document level. If you don't have it as a discrete data element if it's somewhere in a document, just that –

Clem McDonald - National Library of Medicine - Member
No, I'm saying you've got to pay attention go the initial source. So, the initial source that you can do angle – and the physical therapists do this all of the time. The range of motion. And there are variables in LOINK, for example, for reporting that. But that's going to have to be entered by a clinical person or a nurse or somebody. That's going to have to be hand entered. All of the medical records are generic programs that can take variables that they invent of any kind and capture them. It's not new software development.

Sasha TerMaat - Epic - Member
The challenge with that, Clem, and where I would, I guess, give some alternative perspective is that the approach of just saying here's a generic way to add any kind of data element and exchange it is not necessarily consistent with the principles of user center design and integrating the capture and the use of the information into a workflow in a way that is aligned with the users' feedback and the other factors that would influence their workflow. And so, I would –

Clem McDonald - National Library of Medicine - Member
I've done this for 20 years and so have you and I don't think – you want to have good interface and you want to apply it to all of it but you've got form generators. And they're pretty well done and you just do it. Let's say you want it, you do it now.

Steven Lane - Sutter Health - Member
Yeah. But I would also add that if something is going to be put into USCDI and all of the systems are going to be expected to develop the capability to capture it and to exchange it, it's going to need more than just a custom design field and a form generator. It's going to really need to be defined and baked into all of the systems. And that's a bigger deal.

Clem McDonald - National Library of Medicine - Member
I'd like to walk you through it. I think you're making it harder than it has to be. Pulling it out of a Dicon system be more work. That's where some of this stuff would be with some of the measurements that were already there and then, you'd want **[inaudible] [00:56:37]** can do different work.

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

Well, to get back to Sasha's variable timelines, variable for many different reasons, in a sense is sort of the strength of the USCDI process. It looks like it, at its shortest, is going to be at least two production cycles, which will be at least a year. At its longest, it's probably six production cycles or three years. So, let me ask Sasha your sense. Is that a reasonable timeline if you had assurance that three years from now this set of data or data classes will need to be moving? In general, is that a reasonable timeline?

Sasha TerMaat - Epic - Member

I guess the questions that developers will as at what point do they have enough information, a specification, standards, sufficient knowledge that something is prioritized and requested and then, how big is the project. And so, I don't think during that whole three year period you would necessarily have all of the prerequisite information. It seems like some of that only comes in the latest stages of the prioritization process or the promotion process.

Clem McDonald - National Library of Medicine - Member

That's all probably true. But I can make another distinction that hasn't come up. So, if you're assuming that every patient will have these variables be specified then, you've got a different problem. What I would propose is you make a table for clinicians who want to record it, not require it for everybody because you've got to do a cardiac echo to get an ejection fraction. There are all kinds of time costs to putting this stuff in if it's not specific to a particular need.

Christina Caraballo - Audacious Inquiry - Co-Chair

Shall we go ahead, we've got about 30 minutes left, and which of your – since we just have some silence, does anybody have any final thoughts on this? Feel free to jump in. But maybe we move on to looking at the comments in the lifecycle and submission info. Before our next meeting – this is our last meeting before the meeting with the HITAC. So, it would be great to present some of these preliminary recommendations. We're going to skip over the promotion model guidelines for right now. But the areas of focus for the lifecycle submission info and permission criteria and anything for guidelines are going to be informed by those. So, if we go into the promotion lifecycle for submitted data elements, we started to look at the task force's thoughts and put together some just draft recommendations that we'd like to review.

So, this first one on the submission cycle, we had supported the concepts that anyone can submit. Right now, they are under comments and we are proposing that there is an unclassified and proposed section just trying to summarize this. But let me just go ahead and read it since it's an actual recommendation draft. So, we support the concept that anyone could submit a data element via an open comment process. However, the data elements need to be classified. We're recommending to replace comments with unclassified and proposed. Unclassified would be defined as not having been reviewed. And proposed are data elements that have been reviewed but are not yet classified as Level 1 or Level 2.

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

Actually, Christina, that sort of raises one of the key pieces of how do you get from submission from the basement to Level 1? So, there's a set of criteria.

Christina Caraballo - Audacious Inquiry - Co-Chair

Yeah. And that we've got in the promotion criteria from Level 1 to Level 2. This section right here – what was that?

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

I'm going back to an earlier level from getting out of the proposed section to Level 1. How do you make that jump? And is that sufficiently clear?

Christina Caraballo - Audacious Inquiry - Co-Chair

In this what I had in my head was not that stage but more of you enter in as a comment and anybody can enter a comment. And then, once it's entered into a comment, it's unclassified. It's no longer a comment but it's not been classified. And then, meaning it hasn't been reviewed yet by ONC so it's still waiting to be looked at. And then, once ONC reviews it but it doesn't go into Level 1 or Level 2, it is kind of "classified" as proposed meaning we've reviewed it but it didn't go to a next level. So, that's kind of what I was thinking about that. It wasn't necessarily a phase just a notice to the industry and anybody who is looking that ONC has or has not reviewed the comment.

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

It sounds like an orphanage to me.

Christina Caraballo - Audacious Inquiry - Co-Chair

If we want to add more around – I hear what you're saying with the stages. This was just a way – we had a bunch of comments in discussion with the task force that just having this as a comment didn't capture labeling it well. So, that's where this recommendation came from was that discussion. We seem to have consensus that comment, just simple comment, wasn't the right term.

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

So, ONC will review all of the proposed elements when classified. They'll decide whether they go into Level 2 or Level 1 or neither. The ones that go into Level 1 and Level 2 have had clear specifications. So, the question I'm asking is how do you get out of the classified/unclassified/proposed data elements that have not yet met the criteria for Level 1? What's the machinery that gets you out of that category into Level 1? How does that happen? Who is going to do it? In my mind, this is where Steven's affirmative action group kicks in.

Christina Caraballo - Audacious Inquiry - Co-Chair

Yeah, I think, Terry, that discussion lives in the data promotion criteria. So, honestly, if you want to just scroll down and see visually how this kind of correlates, it would be under 4 Level 1, I believe. And maybe we do need to throw a category back in.

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

No, we're not going to make it –

Christina Caraballo - Audacious Inquiry - Co-Chair

I mean, we're streamlining.

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

We are. We'll just call it –

[Crosstalk]

Clem McDonald - National Library of Medicine - Member

Terry, some of this stuff should be kept in the cellar.

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

Yeah.

Clem McDonald - National Library of Medicine - Member

I thought the criteria was things like it was clear, it was tied to something. There were criteria. And I think the first step would be to try to do a better job on making the statement of what you wanted. I thought that was something already in there. And it would be kept alive for a year or something, too, right? Isn't that all part of it? And then, after that, if it didn't get approved, it would have to be resubmitted. I thought there was a process for that.

Adam Wong - Office of the National Coordinator for Health Information Technology - Back up/ Support

This is Adam. The way that the draft document proposes this is that, to your question, Terry, is if something that is proposed for Level 1 or Level 2, ONC reviews. If it meets the Level 1 or Level 2 criteria, it gets inserted to those levels. If it does not, it goes into the proposed level. And the way that it advances from proposed to Level 1 is to achieve the criteria for entry into Level 1.

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

Exactly. And so, my question is how does it get to meet those criteria.

Adam Wong - Office of the National Coordinator for Health Information Technology - Back up/ Support

Well, the proposers have to do the leg work.

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

Okay.

Sasha TerMaat - Epic - Member

Hence our need for a champion for the –

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

Yeah. So, that's part of the concern is that the folks doing the leg work have different length legs. And some of them are still crawling.

Clem McDonald - National Library of Medicine - Member

It's a tough problem because if someone says I want the word glue with no context, you can't do anything with it if there's nobody that can articulate it right. What else can you do?

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

Yeah.

Clem McDonald - National Library of Medicine - Member

And I would guess if there's only one person in the world that wants it, it's probably not something that should be anyway.

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

Yeah. In my mind, that's the conundrum. It's got to have value to a broad number of stakeholders to really advance or have any chance of getting into USCDI. So, that's one of the Level 3 to USCDI criteria. But the question is what's the driver or what's the power, what's the force behind moving the proposed elements through the process. And I think that's my concern that it's only going to be those who essentially have the resources, have the knowledge of the system, have done it before, are used to building this stuff, which may or may not be – it's what that part of the market wants but is that a reason to take out what's going to be some limited seats in USCDI?

Clem McDonald - National Library of Medicine - Member

Well, Terry, I think you've got to face that this is a tough world. Every single thing just can't be there. I won't name places but there are some systems that let any researcher who wants load in some variable and say you've got 1,000 – you get hundreds of variables that are almost the same with just different shades of meaning. And it's really easy to get it in. You don't have any barriers. But then, people who want to use this thing have the problem of figuring which one do I want to use and they tend not to use it at all. So, that's the challenge. If you're going to be proposing things they're going to use for sharing, you better have some group of people who want to use it on the other side, not just one person who really likes it or one specific group.

The real problem is that they're going to have populations who may be interested in the space that have no idea of how to express it. And you can't get it to a point that it would be useable. It's unfortunate and maybe we hire helpers. Maybe that's what you want so people who know the business and will help articulate a thing that has some value but the people can't express it right. That might be the answer. Maybe that's the champion you're talking about.

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

Yeah. That's sort of the strategic vision. If someone has a view of where we want to get our

learning healthcare system going and also is able to identify some of the gaps, some of which may be proposed data elements that no one else was able to push. It's a complicated process and we're just – my concern is that we just leave it to the market, which is a force to be reckoned with and an effective one. But it may not be sufficient for what we need.

Clem McDonald - National Library of Medicine - Member
Well, the other choice is either dictatorship or just randomness. So, I think what you probably want is someone who reviews it wisely at ONC and maybe there is some place they could pass to another team that could help reshape things that look promising into something that would be more passable without having huge force behind them.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah.

Sasha TerMaat - Epic - Member
Terry, is there a path of revisiting at some point? I guess the reason I ask is because it seems like, in the short term, by which I mean the next several years, we have plenty of data classes, even ones we've just talked about on this call that makes sense to be considered through the promotion model that do have stakeholders who seem like they could participate in the process and that might give us more knowledge about what that even means as far as how the process works and what needs a shepherd and what the role of the shepherd is. And if after a few years of using the process, it seems like there are particular stakeholders who are not able to shepherd their interests through the process or that the process needs to change or that there needs to be special assistance, we might have more of an idea about how to best approach that than we do brainstorming today on the call.

Clem McDonald - National Library of Medicine - Member
That makes a lot of sense because we're going to **[inaudible] [01:13:11]** anyway, right.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Good point. And we'll learn. I don't know if we even need to call that out but it might be worth a sentence that just says we'll learn where the gaps are and we should be prepared to fill them.

Clem McDonald - National Library of Medicine - Member
That's a good idea.

Christina Caraballo - Audacious Inquiry - Co-Chair
I think that makes a lot of sense but I would also caution against the kind of business as usual because one of the things that we're trying to do is put a process in place where the voice of many occurs and not the same stakeholders that were focusing on creating a process that just continues to address a sliver of the market. And, Sasha, I completely agree with you. Let's see how this works. But I would also caution us against just going down the same path without putting something in place to at least begin to engage other stakeholders.

I think that's where we were talking about this health IT, what was the new name, IT Coordinating Council and maybe that goes beyond a federal approach and we recommend to ONC that they start to get out into the community and engaging the public health agencies, engaging with the consumer groups, engaging with some of these safety net hospitals, schools, prisons, and start just inquiring about the data and information they need. And maybe that's our first step. So, it's a mix of what we're kind of all saying. But I do think something needs to start where we're laying a foundation to engage the broader community.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
To actively engage rather than let the broader community come with their offerings.

Christina Caraballo - Audacious Inquiry - Co-Chair
Some type of balance.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Do we have public comment to do soon?

Steven Lane - Sutter Health - Member
Yes.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Thank you, Dr. Lane. Roughly in one minute.

Steven Lane - Sutter Health - Member
I know the routine.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Okay.

Christina Caraballo - Audacious Inquiry - Co-Chair
It's on our schedule.

Cassandra Hadley - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. Shall we go to public comment?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Sure.

Cassandra Hadley - Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Operator, can you open the line?

Operator

If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

Cassandra Hadley - Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Do we have any callers?

Operator

There are no callers at the moment.

Cassandra Hadley - Office of the National Coordinator for Health Information Technology - Designated Federal Officer

Okay. Thank you. Terry.

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

Okay. All right, gang. So, Christina.

Christina Caraballo - Audacious Inquiry - Co-Chair

Yes. So, let's see. Do we want to continue? We've got two options here. Our next phase of discussion was to be to kind of iron out some of our thoughts around the promotion criteria, which is where we are in this document. Or we could review as a task force some of the recommendations that we started to formulate based on feedback so far.

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

How about if we all pick up the Google doc over the next two weeks and really go through it and add thoughts. And then, Christina, you and I will see if we can sort them out and then, in the recommendations.

Steven Lane - Sutter Health - Member

I like that approach because I think we should talk about the promotion criteria, shouldn't we?

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

Yeah.

Christina Caraballo - Audacious Inquiry - Co-Chair

Let's stay right where Adam is. Okay. I'm just getting to where we are on my desktop. We did start – we had a little more discussion on Level 1 on the last call. And we have some recommendations. We hadn't discussed Level 2 as much but we can go ahead and start with Level 1. The first part was that we had wanted to better define a developed use case. I'm going to read through some of this a little bit and see where we have some questions. If

everybody wants to just take a look at this right now.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
And are we going to be content standard agnostic?

[Crosstalk]

Steven Lane - Sutter Health - Member
What exactly do you mean, Terry?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Well, it just means that as long as you've got one content standard that you're meeting, do you care if it's SnoMed CT or LOINK or –

Steven Lane - Sutter Health - Member
I don't think we should get into that.

Sasha TerMaat - Epic - Member
I agree.

Clem McDonald - National Library of Medicine - Member
As long as it's being described, it's self **[inaudible] [01:19:39]** HL7 and others.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
So, anything cited by HL7 and other STOs?

Steven Lane - Sutter Health - Member
Well, how about an anti-accredited standard development organization. Is that enough?

Clem McDonald - National Library of Medicine - Member
That's all we got.

Sasha TerMaat - Epic - Member
Yeah. Ken had actually originally written his recommendation and he said if the healthcare services platform consortium publishes a Fyre profile for cardiac ejection fraction, for example, that should be sufficient saying that yes. So, it's more inclusive.

Christina Caraballo - Audacious Inquiry - Co-Chair
That example a little further down in the Google document was a reference to this comment or recommendation. So, on this recommendation, I had a comment here. It was to provide additional clarity for the requirement to demonstrate that the data element has been tested for exchange. Do we want to make recommendations for kind of a base level criteria here? What does tested for exchange mean? We had a lot of questions in the comments but no

suggestions.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Is that like a connectithon? Or is it a limited deployment in a system?

Clem McDonald - National Library of Medicine - Member
Those are good questions but some of these things may be not easy for us to decide. And we trust in some of the wisdom of the ONC reviewers. I'm not part – that may be hard to define exactly what's meant.

Al Taylor - Office of the National Coordinator for Health Information Technology - Staff Lead
This is Al, just a suggestion. One of the new criteria for HL7 balloting is limited testing or pilot testing for even first ballot for some things in HL7 for Fyre. And that might be considered to be adequate initial testing for exchange to meet at least this criteria. That's just a suggestion. Obviously, we haven't codified it yet. But something like that would certainly qualify as limited testing. Would it be sufficient limited testing to meet the requirement for comment or Level 1? I think maybe that might still be up for debate. But something like that is probably reasonable.

Clem McDonald - National Library of Medicine - Member
Well, it gets tricky because if you can send – cardiac echoes have maybe as many as 200 measurements they can take. And if you can send one, you can send them all. That's my bias anyway. And then, some cases may need to have some and some others depending on whether it's a mitral valve or this. So, it could get complicated if you're really on to a specific variable that is in the category –

Christina Caraballo - Audacious Inquiry - Co-Chair
Yeah. Let me rephrase the question. So, right now, it says demonstrate that it has been tested for exchange. And maybe it's not us defining so much the base level criteria but putting in a recommendation to, I don't know – what our recommendation is for that base exchange and not pointing to anything specific but saying something like this could be limited or very inclusive versus kind of very stringent testing. I don't know. Just thinking through this pointing to the fact that it just says it has been tested for exchange.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Are there any –

[Crosstalk]

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Are there other groups that have definitions for adequate testing that we could just point to?

Clem McDonald - National Library of Medicine - Member

It's so specific, the different cases.

Christina Caraballo - Audacious Inquiry - Co-Chair

What about examples of finding the base levels that we know and not being prescriptive but giving examples of kind of what we're thinking? One of them maybe incorporating Al's suggestion.

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

Yeah. It seems to me that this would be one of the first questions that anyone submitting proposed elements is going to ask. What's adequate testing? Is the connectithon an example of adequate testing?

Clem McDonald - National Library of Medicine - Member

I think it could. But the other one would be it's just used in practice. But that's not testing. It's used in industry currently. So, Bob McClure is writing in the chat. He said it's a GL7. I said that's an interesting one. But he said to allow any test. HL7, IHE, HIMMS. He said multiple organizations have to understand and implement. And the criteria are multiple organizations can understand and implement and that's the criterion for adequate testing. Thank you, Dr. McClure. Does that sound reasonable what Bob is typing? Essentially, we point to the big groups that have already specified what it means for adequate testing. Okay.

Sasha TerMaat - Epic - Member

Those seem reasonable to me as guidance. What's the consequence of having a wide definition of testing for this purpose? This is Level 1, right? And so –

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

This is what gets you into Level 1.

Sasha TerMaat - Epic - Member

Right. So, at this point, it seems to me that it would be reasonably safe to err broadly in terms of the definition of what testing was expected, right.

Clem McDonald - National Library of Medicine - Member

Yeah, I think so.

Christina Caraballo - Audacious Inquiry - Co-Chair

I would agree with that.

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

Yeah, good point.

Sasha TerMaat - Epic - Member

So, I certainly agree with Rob's suggestion that the type of test he mentioned, whether it's HIMMS interoperability showcase or IHE's testing and so forth would be very reasonable

things to point people towards as examples.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Okay. Well, we are past the hour. And I think Rob has given us some more things to think about. His last comment is that does seem to be a high bar for an intro into Level 1. So, something for us all to think about over the next two weeks. I think let's wrap it up at this point and wish everyone a happy Fourth of July.

Steven Lane - Sutter Health - Member
So, are we meeting again before the HITAC?

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
No. That would be no. I think we're meeting after.

Steven Lane - Sutter Health - Member
Right, yes. I'm really glad we started this discussion. About the advancement criteria. I think it's really important. So, let's make that a focus next time.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Okay.

Clem McDonald - National Library of Medicine - Member
Thanks, all. When do we meet next? When is the meeting?

Christina Caraballo - Audacious Inquiry - Co-Chair
The day after the HITAC meeting.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
Yeah. The 13th. Hold on, I'll see.

Clem McDonald - National Library of Medicine - Member
Thank you.

Terrence O'Malley - Massachusetts General Hospital - Co-Chair
The 12th, all right. Okay. So, this is a wrap. Great job. Thank you all.