U.S. Core Data for Interoperability Task Force

Transcript

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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
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Al Taylor	Office of the National Coordinator	Staff Lead
Adam Wong	Office of the National Coordinator	Back up/ Support
Johnny Bender	Office of the National Coordinator	Back up/ Support

Operator
All lines are now bridged.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. Lauren, are you gonna take this, or do you want me to start?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
I am so sorry about that. I was on mute. Thanks, everyone, for joining the call today. With us so far, we have Terry O'Malley, Tina Esposito, Sasha TerMaat. And hopefully, the others will be joining us here in a few. So, Terry, I'll turn it over to you.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Thanks to our small but powerful crew. So, today we just learned that our final transmission letter is due on 5/8 rather than after our 5/10 call. So, what that means is that today we will go through the proposed transmittal letter and correct some of the slides, make sure the language syncs up. And then probably turn this around and send it out over the weekend for people's final comments so we can submit our letter on the 8th. So it's really a tight timeline.

So that's the main news of the day. So, what I hope we'll do on this call is actually go through each item for which there was no consensus based on the ballots and see what we can do. And the idea will be is to come to a consensus, which doesn't mean unanimity. It means general agreement because we'll probably never get them perfect. But if we can get them close enough and acceptable than that's good enough. So unless you have a really strong allergic reaction to the item that's being proposed, vote yes. But another wise vote no. And we'll discuss it, and hopefully, we'll be able to iron out any of our real serious objections during this call. Because it's not so easy to iron them out when we're doing the presentation on 5/13. So hopefully, we'll be able to square things up now.

So, any questions, comments, or concerns?

Tina Esposito – Advocate Aurora Health – Member
No. Dive in.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
You're in, okay. All right. So, two buckets. The first one is pretty easy; well I hope it is. We'll see. It's sort of a general issue, many people raised it. Is do we want to "recommend" that ONC does XYZ or do we want to ask ONC to consider XYZ. So that's the first vote. And several people have already suggested we make it recommend. So what do we think of that as our recommendation? That we change our text to read recommend rather than consider?

Tina Esposito – Advocate Aurora Health – Member
Is that about a specific item or universally?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, probably universally unless it's something that we agree on that we either want to move or postpone or it's just sort of a general. Make it a recommendation, but we might recommend that ONC investigate rather than implement. Something like that, so. But generally, just make our recommendations as such and qualify them as we need to.

Tina Esposito – Advocate Aurora Health – Member
I wonder – I'm fine with the recommendation where we have a very clear understanding of here's the problem and here's what we think will help mitigate that. I wonder though, and I recall thinking this as I was going down the spreadsheet if there is perhaps an opportunity to use both when it's clear. Like we're trying a solution, but in areas where maybe the problem isn't fully clear, or it's going to take a little bit more thinking or time, maybe we use the term consider. And I guess I reflect that specifically to the quality measure item, that was sort of lower end on the recommendation. I don't know what line item it was. But 29 or something along those lines.

And I think the intent is excellent. I think the way in which we're trying to get at it may not be quite right. And so, when we have an area like that where everyone's pretty much for the idea but how and what we're recommending isn't quite clear, maybe that's more of a consideration for ONC.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, yeah. And I think that makes sense. And what we can do when we go through the items is assume, we're going to make it a recommendation, but if you think it ought to be a consideration at that time then just raise it, and we'll figure it out. How's that?

Tina Esposito – Advocate Aurora Health – Member
I'm good with it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Okay, so the next things we got to do is going to be, we'll just go over each of our recommendations where there is not a consensus. There were fortunately about 30 elements where pretty much everyone voted yes or yes with minor word changing in the transmittal letter. Most of which didn't alter the meaning but made it clearer. So the ones that we couldn't, I just sort of put down for discussion. So, I think, Johnny, if you're on, it might be helpful to pull up the all ballot spreadsheet and go to the last column.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Yes. Just give me one second.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. And then we will add another column after the last column for sort of our adjudication. And I meant to thank you guys, really, for all the work to get this done. This is really a short timeline.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Version five, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Version, V.4 I think. Do we have a V.5?

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Yeah, I have a V.5. You sent it…

Adam Wong – Office of the National Coordinator for Health Information Technology –Back up/ Support
You know what, Johnny, the one that I sent. This is Adam.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Oh, okay. Got it. Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Version control happens everywhere.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
One second, I got it. Pulling it up.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And what we'll do is we'll do real-time editing. Johnny will do real-time editing.

Tina Esposito – Advocate Aurora Health – Member
Is there a Google Doc that we should be following along with this, or just they'll pull it up on Adobe Connect?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, it's just gonna go up on Adobe connect, although, there's no reason why we couldn't send a file out if that's easier. Yeah, I think that's actually going to be easier unless we can get this really big.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Yeah, I mean I can…

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, actually if you click on the, you know, expand to the full-screen button. The Adobe Connect it actually is legible. So go all the way to the last column. Composite decisions. And let's add one more column after that. And that can be our adjudication. And then we'll go. And I think, unless someone's got a preference, we'll just kind of go down the list.

So the first one is on the address. And the question was raised, sort of how many addresses do we need? How far back should we go? And there were at least two schools of thought. One said any address you can get will help you in patient matching. And the other ones were more parsimonious and said just the last one. You're current and last. And I don't know what the right answer is, but do we have a group opinion?

Sasha TerMaat – Epic – Member
So just to clarify, this is Sasha. I apologize if I ask questions that have already been discussed because I'm trying to make sure I get up to speed. This is for inclusions USCDI. So this doesn't have a data capture implication, it's simply about what should software that is certified to USCDI be able to support as a floor?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Exactly. Right. And there were no solutions for this. This is just we're saying this is a data element that USCDI should contain. ONC can decide whether they want to add this element or this clarification. And then in the bigger process make it part of the certification.

Tina Esposito – Advocate Aurora Health – Member
This is Tina, and I know I commented on this. So here – I have a little bit of experience in the identity sort of realm. And we have evolved immensely of course in the past couple of years. But one of the areas that I think there is an opportunity for, and I think some have explored this notion of referential matching. Where you are looking at a number of data elements from the history that sort of align and pull together a single identifier or a single patient and ensure that all of that information is pulled together.

And what has been sourced or at least cited that would support this effort would be to see all of the addresses, all of the historical demographic data, of someone. Because the challenge you have, let's say as a hospital system is that you are not quite sure how old that piece of demographic data you have is. Is that two address ago? Three address ago? Is a current address? Of someone you have that look back and can see, oh, this may not be the current address, but it was two address ago. It might be the same based on everything else that matches.

So, I think, and I'm just throwing that out there. That's sort of that's kind of where my head was at when I read that. Pulling together then Sasha's comment on what is kind of the need here. My recommendation would be that it should be able to contain more than just the current address if we want to enable referential matching.

That's the business problem. How this – you know, what piece of that is this, that's where I'm getting a little lost. I don't know how useful that was. But I just wanted to kind of give you my perspective as I was reviewing that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. And anyone else wants to weigh in?

Sasha TerMaat – Epic – Member
I might favor actually just making this more generic to say multiple addresses. There could be a case where someone has two, you know, a vacation home or other reasons that they have multiple addresses on file and you would want to use all available data to, I think it was Tina's point, that that would improve matching.

I don't want to imply that someone should back enter like their previous seven address just for the hope that would improve matching. But if you have a lifetime record for a patient and you have previous seven addresses, and one of them is helpful for matching, that sounds amazing.

So maybe it is solved by simply saying that USCDI would imply support for multiple addresses per one patient and not be prescriptive.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, so we might say the current address and previous addresses.

Tina Esposito – Advocate Aurora Health – Member
I would be very supportive of that. I would agree.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. That's kind of what Clem – Clem said the same thing. If you already know some previous address, then pull them forward. If this is the first time you've registered, then you probably have a few you could do. Okay, are we okay with that one?

Tina Esposito – Advocate Aurora Health – Member
Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
There are no objections? The chair moves on, okay.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
What do you want me to note in adjudication? Yes or no or what would you like?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
No so, put our verbiage, and we will assume that that is a yes, and if it's not, we'll have enough verbiage in it to say there are two schools of thought and we couldn't come to a consensus. How's that?

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Does that look good?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. Okay. All right. And then the next one was on content for address. And there were a lot of comments regarding what standard are we going to use. And I basically just said let ONC choose it. Whatever one they think is the best at the time. And it might be the U.S. Postal Service, or it might be something else. So, how about that for a recommendation?

Sasha TerMaat – Epic – Member
Go ahead.

Tina Esposito – Advocate Aurora Health – Member
No, please.

Sasha TerMaat – Epic – Member
So, the way this is phrased at least, and this is part of my confusion, which I think I said that. Is adopting a standardized format seems to imply that you would adopt it in certification. But the current address standard format that I understand which is USPS is not something you could test in certification. It's a way of formatting things in the same fields that anyone would have for address. Like address row one, address row two, city, state, zip, etc.

And so, when I look at this, and I'm thinking, again, this is going to be a USCDI thing which would be tested on HIT modules going through the certification process, you can't do that in the certification process. It could be encouraged, but that's really a data capture or data normalization step. It can't be something that's certified against.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Got you. So all right, I think I understand that. So how would you like to see it phrased that we might all agree on?

Sasha TerMaat – Epic – Member
Well, I guess if we are putting it here, I think we may just need to frame it as ONC should encourage the use of the USPS address format because we recognize that standardized address formats dramatically improve a matching. If we really wanted, as an industry, to improve the standardization of address formats, the way that it would seem to do that would be to have healthcare systems connect up to an address verification API. There are some available today commercially. The restriction from wider use, as I understand it, is cost. USPS has one available that I don't think the license for the purpose of like healthcare matching.

And so, that's not really a USCDI thing. That's like a separate standards thing, outside of this. Maybe something to punt over to the standards priorities task force. But so I guess from a USCDI perspective, I feel like all that could be done would be to say that we recognize the importance of a standardized format and encourage it. From how would we get there? I think the way that we get would be to ensure that there are address verification web services available at a cost that makes it practical for widespread adoption across the industry. And then that healthcare organizations would adopt those.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, I think – all right. So, any other comments on sort of the first half of this? Because I think the second half gets a little out of our scope. I don't think we are going to propose how any of this gets done, so much as what it is, we want ONC to include in USCDI. Do we want them to include addresses in a standardized format and encourage that, but probably beyond that, I'm not sure we need to make a further recommendation? Does that make sense?

Tina Esposito – Advocate Aurora Health – Member
I'm okay. I'm good. This is Tina.

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

Sasha TerMaat – Epic – Member
Will you take the first sentence in the comments as the adjudication?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, I think so. It just got into another…

Sasha TerMaat – Epic – Member
Yes, okay. That makes sense.

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

And we'll move that one over, and we'll make that as an additional.

Sasha TerMaat – Epic – Member
And just for the adjudication comments, I don't think it is actually a question of vender adoption as it is a question of healthcare system adoption.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. All right. Then we had homelessness. And I think the comments kind of fell into two buckets. One is first of all, should it be in demographics at all? And then the second one is should it be in a later version? And I think the consensus was it probably shouldn't be in demographics because it, although helpful, it's not a concept that fits neatly into demographics. And because it is a concept that does not fit neatly and has yet to be fully standardized, whether we ought to postpone this to a later version and make that our recommendation.

So the summary recommendation I would make is we take homelessness, move it to miscellaneous and encourage ONC or somebody to consider it for a later version. Let me make that as the proposal and if any of you guys think, no, homelessness ought to be on the ballot right now and it ought to stay in demographics.

Sasha TerMaat – Epic – Member
I support your proposal. I think it aligns with my feedback, which was that I wasn't sure that the standards supported this designation for matching today and so it didn't really align with demographics or sort of the version one because I think standards work would be appropriate first.

Tina Esposito – Advocate Aurora Health – Member
I would also support. I think I made reference to this in my comments. I think the challenge with this one is not the vision of field but rather how would you script the conversation actually to collect that information. And I think right now, you can pull this. It's not very well, I'm sure, documented or leveraged. But I think that is not a system issue or a field issue, it's far beyond that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, all right. So our adjudication is that we move it to miscellaneous and make it a future version. Is that okay?

Tina Esposito – Advocate Aurora Health – Member
It's fine.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Moving right along. And we will recommend, so the next one was yes. Was an international address. All we're doing is explore, so. You know, that is no stronger than consider, I think. And then we all agreed that phone numbers were a good thing to have and the general consensus was, do we include both mobile and landline? The question was, do we need to make one primary and the other secondary or just say collect all the phone numbers you can?

Sasha TerMaat – Epic – Member
So from a personal perspective, people will ask for a landline phone number, and I put my mobile in because I don't have a landline, and I think that's common. So I have a sense that in when recording data, the distinction between landline and mobile is not super valuable to start with.

What we have found in matching, using phone numbers, is that if you simply cross match against all available phone numbers, the rates go way up. Without trying to differentiate matching what was recorded in one system as a landline with what was recorded in another system as a landline. Just say like, do any of the phone numbers in that system match any of the phone numbers in this system. So I would favor saying collect as many phone numbers as you have, try to match against all of them.

Tina Esposito – Advocate Aurora Health – Member
I would agree with that. And the mobile one is an important one from a matching perspective because it just changes less. It tends to follow a person.

Sasha TerMaat – Epic – Member
Very reliable.

Tina Esposito – Advocate Aurora Health – Member
Yes, much more reliable.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So adjudication would be that we collect any available phone numbers?

Sasha TerMaat – Epic – Member
This is for 2-A, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
2-A, correct. And so…

Sasha TerMaat – Epic – Member
Yes. That would be the adjudication.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, okay. Right.

Sasha TerMaat – Epic – Member
Or just for like precision in wording, I think what would say is that software should support, as we said with addresses, multiple phone numbers. Again, we are not in a position to tell what should be collected or who would record what or any of that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. Okay. So we are recommending that software should support multiple phone numbers. Okay, good. ONC shouldn't consider that. They should take it as a recommendation. All right. Okay. So the next one was doing it include a designation indicating whether the phone number belonged to the patient or to someone else. And Brent said is this going to be an opportunity to mismatch? Steven Lane said to change the number to each number.

So I think the point on this one is primarily, initially, brought up to establish some privacy for adolescents who may or may not want to share – give their parents phone number for health information that they want to keep private. It's a real sticky issue.

Sasha TerMaat – Epic – Member
I would wonder if we should generalize. I mean there are other situations where you would want to know whether a husband and wife were sharing a number or if it was individualized. To just designations of private versus shared numbers.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Excellent. That simplifies it dramatically.

Sasha TerMaat – Epic – Member
And I think that, again, you would want to avoid the implication that you would have to capture that for every phone number you ever enter that in the system. But that if software supported the ability to say that a particular number was private or that a particular number was shared, then you could make decisions correspondingly about if you would use that for communication.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. That sounds great. So our adjudication would be software should support the designation of private or shared for phone numbers. Is that okay?

Tina Esposito – Advocate Aurora Health – Member
That works.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, I like that. That simplifies it a great deal. Wonderful. Okay. And as data elements, the destination for electronic communication. So this one the comments were sort of well what can be destinations? You know what sort of, is it as simple as just an email address or email addresses?

Sasha TerMaat – Epic – Member
I think that raises a lot of questions. And there were a variety of examples given for destinations which included like a web address for a PHR, a direct address, an email address. And the challenging part from an incorporating this into an EHR perspective is that each of those is very different. How you would want to store and use each of those addresses needs to be distinguished. They are not interchangeable if you want them to be actionable.

In my experience, the use of web addresses for a PHR or direct addresses among patients is very low. So I think the primary value for this one, in my mind, would be an email address. So I would start there if we're making a recommendation to add things to USCDI version one.

Tina Esposito – Advocate Aurora Health – Member
I was along the same lines. I have to look to the narrative, and I was just like, oh, we can simplify what we're asking here. It wasn't clear when I read it initially in terms of the element if you will. So I would agree. I would simplify it and say it was an email address that we're asking here. And then consider some of those other items that you just, in addition to the email address there were a couple other examples, I think those would be considerations for future releases or future versions.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so our adjudication would be software should support collecting email addresses and ONC should give consideration to other potential addresses in subsequent versions.

Sasha TerMaat – Epic – Member
Makes sense.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Good. That gets us one step forward and kind of our foot in the door for the next version. Okay, great. And the next one, number four, and just I think evoked a lot of confusion. And I'm wondering if since we simplified three, my recommendation would be just that we drop four.

Sasha TerMaat – Epic – Member
That makes sense.

Tina Esposito – Advocate Aurora Health – Member
I would support that as well.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so drop it. Okay. And again, later versions, once they're collecting more than one address than you can ask people to designate their preference. But if you're only getting one, that's the one. Okay, so this one of the designations of individuals with authority to consent to treatment and data use. The discussions were mainly around sort of what's already in the standards. What's HL-7 saying? What's Fire, what's HL-7 either CCDA or Fire saying. And I think that's a choice that ONC can make. I would say – the general recommendation was that everyone liked this one in thought. It should stay as is.

Sasha TerMaat – Epic – Member
This is just a name, right? When we say designation of the individual, we're basically meaning there would be a name?

Tina Esposito – Advocate Aurora Health – Member
That was the comment. We have to be a little bit clearer. What do we mean? Is that a relationship? Is that a name?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think what it means is there – well, I'll ask you guys. Is there a standardized identity data set? So the individual, what do you want to know? Name, date of birth, contact information, address. I think whenever we ask for someone's identity, we probably ought to be asking close to the same thing. We're asking how do we get in contact with this person? What do we need to know to be able to reach the person who has authority to consent?

Sasha TerMaat – Epic – Member
Yeah, that makes sense. We really want maybe a name and contact information for use. I mean, practically you would probably want to know the relationship too. This is a parent, a guardian, a friend, relative, spouse.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. So should we say software should support the collection of the identity of the individual, blah blah blah? Who can consent, including name, contact information, and relationship?

Tina Esposito – Advocate Aurora Health – Member
That clarifies. That's better.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And I wish we got this group together a long time ago. This is much better.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Were there any more fields you wanted to include there? Name, contact, relationship.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Contact information.

Sasha TerMaat – Epic – Member
Contact information.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Do you want me to put, etc. for it?

Tina Esposito – Advocate Aurora Health – Member
No.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
Yes. Great.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Bold, center, wrap text. Okay. All right. So the last four digits of Social Security. So there are two groups, one, this is helpful, the other, this is an identity theft issue.

Tina Esposito – Advocate Aurora Health – Member
So I commented on this. First of all, it's helpful. Positively, absolutely, to include. I can just tell you from experience, though, that has raised lots of concern. For various – even as simple as a survey where you need a password that would be specific to the team member or the associate. It tends to raise a lot of concerns when you leverage even the last four digits of your Social Security number. So, I think it's helpful for matching. There's no around that at all. But I do think this needs to be considered.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so how about our adjudication is that we ask ONC to consider including the last four digits of the Social Security number?

Sasha TerMaat – Epic – Member
I wholeheartedly agree that any amount of the Social Security number is useful for matching. The language of a designation for the last four digits puzzled me because I was just assuming that it would

be four numbers, but. I think that was correct in the letter but in the B-15 it was just – I was like, what would be a designation for the last four digits of the Social Security number?

Tina Esposito – Advocate Aurora Health – Member
Oh, I see what you're saying, yeah. I didn't even see that.

Sasha TerMaat – Epic – Member
Yeah, and then I looked at the letter, and I think the letter had clearer wording where it was just like the last four digits of the Social Security number. I was like, okay, yeah. That's…

Tina Esposito – Advocate Aurora Health – Member
Yeah, I see. That's right. That should be corrected. I didn't even notice that.

Sasha TerMaat – Epic – Member
We could put something into the adjudication about the pros and cons, right? Like the recognition that it's enormously helpful for matching, but that we're sensitive to the privacy concerns.

Tina Esposito – Advocate Aurora Health – Member
Yes, I think that's nicely worded.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, Johnny, that goes into the adjudication comments.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
What was that? Sorry, I missed it. I was trying to reword the adjudication.

Sasha TerMaat – Epic – Member
I was just saying we recognize it's useful for matching, but we want to be sensitive to the privacy concern.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. And I think what we will do for the adjudication comments is we will put them into the transmittal letter as sort of a next paragraph after each of these as needed. We may have to reword some of them but is that okay with everyone if we do it that way?

Tina Esposito – Advocate Aurora Health – Member
It seems like good context, yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Optional identifiers. Again, about designations. So, again, for patient matching, any number is a good number, I think. So what we're trying to get with this was, first of all, it's optional for the patient to provide it. We're not going to drag it out of them if they don't want to give it. But if they're willing to give it, shouldn't we be able to collect it?

Sasha TerMaat – Epic – Member
I think that makes sense, Terry, and philosophically I'm with you. I mean, but all of these are optional for the patient because our workgroup has no authority to influence data capture. So, I guess, thinking from a – if we recommended that this is in USCDI, what does that mean for ONC writing a certification requirement? They would say well, okay, how do you include optional identifiers like state or federal government IDs? I guess thinking that through unless there's a list of IDs that we would want to be supported, like passport numbers should be in this format and they would go in a field. And state-issued IDs if there's some sort of consistent format or it's format per state or something, and those would go in this field. I imagine we would just have to have a more generic framework or something.

I guess the ambiguity to all of that gives me a little bit of pause. Not because I disagree with the assertion that they're useful for matching. They're certainly useful matching. Our system uses any identifiers that are available in the matching. But when we think about translating this recommendation into a USCDI certification requirement, it seems almost too open-ended.

Tina Esposito – Advocate Aurora Health – Member
So if I recall the conversation right, some of the research that's been done, I think driver's license or state ID, it's interchangeable, has been the number that's more beneficial or very useful from the perspective of matching. So, Sasha if I'm understanding you're saying this is good but clarify what specifically, what ID specifically are you after here?

Sasha TerMaat – Epic – Member
I think if we're gonna make a recommendation for USCDI we have to be specific about what additional identifiers we would want this software to support. So if we said software should support the use of a state driver's license for the purposes of improving patient match rates, I think that's more clear.

Tina Esposito – Advocate Aurora Health – Member
Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And maybe we should also say, because a passport is such a standard, although not widely available if we added that as a separate recommendation. So we'd recommend adding state license and ID, and we recommend adding passport. And we just…

Tina Esposito – Advocate Aurora Health – Member
And leave it at that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And leave it at that.

Tina Esposito – Advocate Aurora Health – Member
Yes, I think that's fine.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Have this other stuff wait for the next version if someone says, the military ID is really essential, then fine. Get in line.

Sasha TerMaat – Epic – Member
I would even prioritize drivers license ahead of passports from like an adoption perspective if we're drawing a narrower line.

Tina Esposito – Advocate Aurora Health – Member
I would agree. I mean, it's definitely much more common. You're much more likely to have a drivers license on you.

Sasha TerMaat – Epic – Member
Right, I don't take my passport to the doctor.

Tina Esposito – Advocate Aurora Health – Member
Exactly.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Not if I can help it. You know maybe we, again, I was thinking of making this two, so 7-A and B, which don't exist or whatever this was. Make it two. Make the first recommendation that it's the state ID or drivers license and the second recommendation that it's a passport. And again, people are going to be – online registration is going to be more common. People will be doing it from home.

Sasha TerMaat – Epic – Member
Yes. I might personally say do 7-B as a consideration for the future and 7-A as we recommend systems should support it. But I can live with either.

Tina Esposito – Advocate Aurora Health – Member
Yes, same. With a bit more sort of global healthcare needs. Because then we get into the U.S. passport. So yes, I feel like I'm all for the driver's license, I'm all in. On the passport, I think they still probably need to be a little bit more conversation around it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so let's make 7-B in a future version. And if ONC wants to move it up, they can move it up. Okay. All right, so moving right along. Self-reported gender identity. Basically two comments, one it doesn't belong here. And the second is, is it a high enough priority to keep it in D-1. And I know Steven Lane is a big advocate of this. Because Sutter has actually made it, put it right prominently in their demographic field. And then the third question was don't you need sex assigned at birth as another field which may drive preventative health interventions. Where gender identity will drive management decisions.

Sasha TerMaat – Epic – Member

I think that actually a fairly robust set of recommendations on how to collect gender identity and like organ inventory. And it's a quite complicated set of rules to know when you should be using each of those fields within the electronic health record. All of that seems to me to be beyond the scope of this. I think it's reasonable to use the standards in the interoperability standards advisory to collect gender identity. Though, I guess I don't know if it's appropriate to do in demographics of elsewhere. I would defer to others on that.

Tina Esposito – Advocate Aurora Health – Member
I was comfortable with it. I do think from a health system perspective, from a health equity perspective, I think it's an important thing to understand and be able to sort of look at from a public health perspective, from that sense. But for folks that didn't think it belonged in the demographic section, what was the recommendation? Where should it be?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Miscellanea.

Tina Esposito – Advocate Aurora Health – Member
In my opinion, I think it's a demographic.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so are we all comfortable living with that? So our adjudication is that we recommend that software supports the collection of self-identified, self-reported, gender identity.

Sasha TerMaat – Epic – Member
Is gender identity ever not self-reported. I thought it always was self-reported.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, that's true.

Sasha TerMaat – Epic – Member
Since gender-identity by definition was sort of. It seems duplicative to me to say it's self-reported, but I am fine with the idea of capturing it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Although, somebody else might assign a different gender identity looking at somebody across the counter.

Tina Esposito – Advocate Aurora Health – Member
Yes, that's what I was gonna suggest too. I think it just maybe underlines that it's self-identity and not necessarily something that someone enters or assumes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. So I put self-reported back in there. Yes, I think that's the – all our training films go over that point, anyway.

Al Taylor – Office of the National Coordinator for Health Information Technology – Staff Lead
Yeah, and I think it makes sense. This is Al. It just makes sense to, primarily, I think it is the distinction between that long phrase, sex assigned at birth, which is what we use to call sex. And this is gender identity, which you know, it's best to distinguish between that. Because just saying self-reported gender identity versus sex assigned, I think that's probably the reason that they use the long phrase.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Excellent. Thank you. All right. So that's demographics. Trumped that one out. Good. So now we're on to provenance. And the ONC proposals, everyone thought were fine. There's no one that thought that authors organization author and author's time stamp were inappropriate for provenance. But the discussion came more about the details that we put underneath each one. Although, there was pretty good agreement, at least on the – you can see where all the yeses are, people were pretty comfortable only using it when author when it's unambiguous. And the question was what do you mean by unambiguous, which is a good question. And I'm thinking ONC has to sort out what unambiguous is. Because they might have to put limits around it. I don't think – I vote that task force members say we think this is important. It ought to be unambiguous and let ONC figure out what that means.

Sasha TerMaat – Epic – Member
I think the tricky part from my perspective is, are we saying that there would be certain data classes where the author would always be ambiguous? Or are we saying that on a case by case basis, I would say, oh, well sometimes, within an allergies data class, the author is ambiguous, and sometimes it's straight forward because then I don't understand how that would be operationalized?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, okay. Yes, I think you're right. I think it almost has to be by data class.

Sasha TerMaat – Epic – Member
I would agree. I guess I would support being more prescriptive. And I know that's maybe a little bit different than your proposal, Terry, of letting ONC Sort it out. But I would say that ONC should identify that in the cases of maybe notes on medications, it is both important from a clinical perspective and more feasible to identify an unambiguous specific person as an author or group of people. There could be multiple people collaborated on a note or one person who places a med and another person who modify it or refills it, but that we should figure those out.

And that in other data classes that we're proposing to use an organization simply. And even with an organization, I think there will be cases that will be ambiguous which organization a particular action associated with. I work a lot on quality reporting, and one of the most enormously thorny problems with quality reporting is how do you associate a particular action with an entity.

So, I can anticipate that in this case too, there might be some cases where it's very straightforward. That clinic A is responsible for a particular allergy data class. But that it might be other cases, where it's ambiguous whether the entry of that allergy was an action attribute to clinic A or clinic B or the hospital in that group.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right, okay. So, how about if our adjudication is, we recommend that ONC… So that ONC, what do we want them to do? We want them to…

Sasha TerMaat – Epic – Member
Maybe identify certain data classes where knowing the specific author is feasible and important?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, that sounds good. In particular medications and notes.

Sasha TerMaat – Epic – Member
Yes, or for example medications and notes since those are the examples we've been using. And I guess even within medications I think the author is quite straightforward when you have a prescription with someone who signs it and way less straight forward when you have author when the patient comes in and says oh yeah, I take aspirin every day.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So maybe we say for notes and for medication prescriptions and just make it really narrow. And we can get, again, it's going to be a V-2. Okay, okay with that?

Tina Esposito – Advocate Aurora Health – Member
Good.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So 10-B is really sort of the flipside of this. Essentially, we're saying in all other cases, use the author's organization. For all those data classes. Sound fair?

Sasha TerMaat – Epic – Member
Yes. I think instead of the ambiguous language we would maybe want to say for other data classes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. Use the author's organization.

Tina Esposito – Advocate Aurora Health – Member
That works.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So we will take out the ambiguous stuff and unambiguous, and we will just say do it here and do this there. Whether you think it's ambiguous or not, we don't care.

Sasha TerMaat – Epic – Member
Right. The ambiguousness is sort of why our background. But not a good definition.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, it's terrible. Okay, good. Much better. Okay. Then the author's timestamp was fine. So we should just change 11-A and 11-B, just drop the same verbiage that just says use author's timestamp for medication prescription and notes and use author's organization for all of their data classes.

Sasha TerMaat – Epic – Member
What's the timestamp of authors organization?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, so that's the other thing. That's 11-C, so what's the definition for timestamp?

Sasha TerMaat – Epic – Member
Yes, I guess I'm uncomfortable agreeing with 11-B pending what 11-C is. Realistically, even with an author, I'm not sure that we can have an author's timestamp like the text proposed. I think we almost have to say that this is the data entry timestamp.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Is that okay with everyone else?

Tina Esposito – Advocate Aurora Health – Member
It's fine.

Sasha TerMaat – Epic – Member
Or punt it to an implementation guide or something to define more clearly.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
You know, I'm in favor of limiting it. I think the comments that you guys are making are really helpful because we're focusing in on what it is what we really want to be done. And I think constraining each of these items is probably a good idea. So maybe we just say that we, for author's timestamp and for the – we use the same timestamp for author and organization, and that is blah, blah, blah. The time in which the data element is available for use by someone other than the author. I mean, that's kind of what we had in the transmittal letter. And then we just have one timestamp. Essentially, it's the organization's timestamp.

Sasha TerMaat – Epic – Member
I'm just really uncomfortable with that definition because I don't know that that's the way it's measured.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So should we just say use a single definition for timestamp for both author and organization and punt the definition?

Sasha TerMaat – Epic – Member
Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And then we want specific, or we can say that…

Sasha TerMaat – Epic – Member
Or we almost want to edit 11 more simply just to say that we would amend the author's timestamp to a data entry timestamp or just timestamp generically noting that it needs definition.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So should we reject the author's timestamp and just say in its timestamp just substitute – but again, we're going to have times when we know the author. But what we'll see is the organization's timestamp, wouldn't we?

Tina Esposito – Advocate Aurora Health – Member
I'm actually almost in favor of punting this to a definition guide. Because I feel that this could be something where, you know, first available, earliest available time. This is a challenge. I think depending on the use case it may vary.

Sasha TerMaat – Epic – Member
I mean if I just think through a few of the data classes, let's say patients date of birth, what's the relevant time stamp for that? When did it happen? I mean that's kind of stupid. But when it was entered into the system? Do we even care about when it was entered into the system? If it was a typo and it was edited, then do we care? I guess, and so I struggle. And then you think vitals. Someone has a vitals monitor hooked up to a patient in the hospital. There is maybe some sort of lag between when the vital is measured and when it gets through, the wires into the EHR. Do we care about the measurement time? Which is probably what's recorded in the EHR since that's more clinical pertinent? Or do we care about the time that it was available for others in the system, which is several seconds later?

And so I just, when I think through specific examples this gets so enormously complicated. And I don't think the complexity of that is merited. Yes. So maybe I'm with you, Tina. Maybe we need to punt this separately, or just say timestamp and let each implementer figure it out a little bit because it doesn't super matter. Except I guess I don't even think it's worth capturing for things like date of birth.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. And again, remember this is for provenance, so.

Sasha TerMaat – Epic – Member
Yes, but every data class has provenance associated with it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right, but the provenance – I kind of look at provenance as being a local phenomenon. So it's what we're asking is the system that generates this data element is able to identify it and assert it's provenance. I don't care how they do it. You know, they may use Roman numerals. But it's really if I

went to that organization and said tell me about this data element. When and where did it come from? However they do that is fine with me, I don't care. As long as they do it uniquely.

Tina Esposito – Advocate Aurora Health – Member
So then I think what we're saying is we're not going to define timestamp. We would take out maybe the author's timestamp because we've lost the concept of the author, so that's not super meaningful. And instead, just say accept timestamp as a proposed data element with the expectation that each system would have to apply timestamp.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. So that simplifies it. So we were going to say – okay. So I think the adjudication, Johnny, is amended author's timestamp to refer only – change author's timestamp to timestamp. And if that's to be defined by each system.

Sasha TerMaat – Epic – Member
Yes. Or locally implemented or something.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. Okay, or it should be locally implemented. Okay, that's great. Yes, because we don't care how they put the stamp on it, we just want to know that they can use it to establish provenance.

Tina Esposito – Advocate Aurora Health – Member
And maybe, Terry, kind of that sentence, I would TF as sort of the intro into this recommendation. Because I do think this is an area that gets a little bit. Stepping back is hard. I mean, the intent of this is provenance, and I think just saying that up front I think is helpful.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So make that a lead into the entire section?

Tina Esposito – Advocate Aurora Health – Member
Well, particularly around the timestamp. Just acknowledging that this is not intended to be anything more than just verifying the information.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, Johnny, you wanna add that to adjudication comments for the timestamp.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
I will just start this section with…

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well in the adjudication comments. Add to adjudication comments, the fact that timestamp is only to assist provenance and is locally implemented.

Tina Esposito – Advocate Aurora Health – Member
At least in version one.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
In version one, right. Okay. All right. We are going to – right. So we are going to get rid of 11-A, I think you are right, Johnny. We don't care anymore about the author's timestamp or organization timestamp.

Sasha TerMaat – Epic – Member
Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, and we don't care about all that other stuff. Okay. That makes sense. Drop, drop, drop.

Tina Esposito – Advocate Aurora Health – Member
Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, great. All right. So this one is sort of depending on whether knowing the organization is going to be important to establish provenance. If that's the case, you need a unique organization identity. That logic is correct.

Sasha TerMaat – Epic – Member
Would this be like an HL-7 OID?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
OID?

Tina Esposito – Advocate Aurora Health – Member
That's a good point.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. I guess the sub-question is there already an existing taxonomy that we can use. So is it an HL-7? OID does it already exist in a way that is broadly applicable to things other than medical providers? Medical broadly? Like my big concern is doing it extend to non-medical providers to support services which are essential to the care of my patients.

Sasha TerMaat – Epic – Member
Well, for a lot of HL-7 based exchange, the organizational identifier as I understand it uses the OID registry that HL-7 has. But I might have to do more research with colleagues if we have more questions about that. It's not my area of expertise.

Tina Esposito – Advocate Aurora Health – Member

And if I recall, I think what was being proposed as part of this conversation was just that there are identifiers that exist for hospitals and providers, but that may not be the case for other examples. I know, off the top of my head I don't recall. Because we were saying, nursing homes be included?

So, I think the identifier's important, and I was supportive of it. I think what I read in the comments though, or some of the feedback was that there were examples where there was no identifier or no standard identifier that could be leveraged.

Sasha TerMaat – Epic – Member
Yes. The other challenge was, in my mind, some of the identifiers that were listed as examples, NPI, Tax ID, etc. Are not necessarily practical to match to the actions that we're talking about above. If hundreds of NPIs, thousands of NPIs, and dozens of tax IDs are all part of one system, you are back to the same ambiguity about how you associate the right one with the data class for allergies updates.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So how about if we make our adjudication that we just take it as is written. Add a data element a unique organization identity and lead it at that and let ONC figure out the best way to do it.

Tina Esposito – Advocate Aurora Health – Member
What's the best one at this point, yeah.

Sasha TerMaat – Epic – Member
Due to the uncertainty, should we make it a recommendation or a consideration for the future, I would vote consider?

Tina Esposito – Advocate Aurora Health – Member
I would say consider as long we're not – I just wonder, are we over thinking it. Is there at least a starting point? So I guess I would consider there is there a number out there that's leveraged enough where this would not be as complicated, but if there isn't then yes, I would say move it to version two or three. I mean, if the majority of elements that are being transmitted or passed, do have some sort of identifying the number that currently is in use and exists, then we should absolutely leverage it.

Sasha TerMaat – Epic – Member
Well, that would still be possible with a consider. I guess the consider just sort of reflects our lack of certainty rather than a recommendation where we had a higher degree of confidence in the readiness of the solution.

Tina Esposito – Advocate Aurora Health – Member
Yes, that's fair.
Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so consider adding a unique organization identity and implement in V.1 if they have a good candidate, I don't know.

Sasha TerMaat – Epic – Member

Yes.

Tina Esposito – Advocate Aurora Health – Member
Yes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And we don't have to say what they can find in version two, where it's going to go if it doesn't go into one. Okay. And this is another, sort of the same thing, tricky one. And the only solution for – since the United States Congress has declared that the U.S. government is not going to spend any money on a national patient identifier. And no one else – well, no one can use government-supported money to do it. Then the only alternative to that I can think of is merged enterprise patient registries. So Partner's Healthcare has one, you know. Sutter has one, Mayo. So there are a lot of large enterprises that have master patient indexes. And the question is can we leverage those? We won't get everybody, but we'll get somebody.

Tina Esposito – Advocate Aurora Health – Member
But Terry, you're referring – like Epicure has an enterprise master patient index that pulls together data for the patient across disparate systems and claims data, etc. Are you saying to leverage that ID?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, leverage. Just as a possible alternative to nothing.

Sasha TerMaat – Epic – Member
How would that be useful for someplace else, right? Like that's only a local solution, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, so I look at it ultimately claims like the HIE exchange network, starts off local, then get's regional, then national. Just as a starting point.

Sasha TerMaat – Epic – Member
I would say it would be more useful, and this is a little bit of a different approach, but to have a standard way to designate not the identity of the patient, but just that this was – since we're talking about things that are recorded on the context of a patient record, that it was patient reported. And so that's not like the identifier of the patient, but it is in the context of the patient's chart useful to say oh, well the fact that this patient was taking aspirin was patient reported so that I know that that reporter of that was the person whose chart it is.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Interesting. Yes, that's actually a great clarification. I like that.

Sasha TerMaat – Epic – Member
And that doesn't provide an identifier across systems, but if you get a chart from another place and you see that that med was patient reported, you know that the owner, the patient in the chart

reported it, so it's still useful. Now that said, I don't know if the standards support that today. So this might be one of those ONC should consider encouraging standards to do that, but.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, I think we can recommend it. And again, if ONC likes it, they'll find a standard, and if they can't find a standard, they'll lean on HL-7 to come up with one, or somebody. So I like that approach so our adjudication would be out of the data element, a designation of when the data is patient-generated.

Sasha TerMaat – Epic – Member
So just another question, is this really a data element or is this an author of a standard way to say this is self-reported, patient-reported? Because it would not necessarily need a separate data element so much as it would need that the author element about that particular thing would be the patient.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
How would you – you're doing great on phrasing. How would you like to phrase that one?

Sasha TerMaat – Epic – Member
I would say, recommend ONC develop a method to standardly indicate when the author of patient-reported data is the patient.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Is that okay?

Tina Esposito – Advocate Aurora Health – Member
The author of patient-reported data is the patient.

Sasha TerMaat – Epic – Member
Or when you have patient-reported data, just record the author as a patient. That was more straight forward.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So let's just say that. Now, Johnny, you're going too far. There's not an indicate – have the software be able to indicate when the patient is the author of the data.

Sasha TerMaat – Epic – Member
Yes. That makes sense.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. That's much clearer. All right. Good. So those are the hardest ones. Clinical notes were – generally, everyone was fine with everything that ONC proposed. With our one limitation we just said, laboratory narrative, we just want to make sure people don't use it as an excuse just to dump a text blob.

Sasha TerMaat – Epic – Member

I agree it would be bad to dump text blobs into them. But again, this is not about using this is about certification requirements for HIT systems, and I don't know how you would write that into a certification requirement.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, no I think you are right. I don't know how you would do it either. So should this one be we accept laboratory narrative, and we encourage ONC to advise that this only be used for narrative and not for discrete elements?

Sasha TerMaat – Epic – Member
I actually, in conversation with my colleague here who are more expert in CCA templates and lab data formats than I am, their feeling was that the lab results data class of USCDI and this proposed notes data class were duplicative. And that it was more appropriate to include them in the lab's data class narratives when that is the information that is available about the result. Either the entirety of it or some narrative content in addition to a structured result. And that it was therefor duplicative to have it as a note and less relevant to have it as a note because it's already included in the more structured lab's data class. So I would actually favor not accepting the laboratory narrative as a proposed data element, feeling that it more appropriately belongs in the lab's data class.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, so I think we're getting a hint here. So, Lauren, would you ask to ask for public comment?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sure. And operator, can we open the public line?

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

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you. And any comments in the queue.

Operator
There are no comments in the queue at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, we'll check back in a few minutes. Terry?

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

Let's go back to where we were. Thank you. And so our adjudication is not to accept the laboratory narrative note but rather make the narrative part of the lab notes, the lab module, what do we…

Sasha TerMaat – Epic – Member
Well, in our minds, the laboratory narrative was actually already part of the laboratory results data class.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So let's just say, so the adjudication is not to accept it because it's duplicative and the narrative's already part of the results data class. Okay, good.

Sasha TerMaat – Epic – Member
We have the same feeling about one of the other ones. I think it was diagnostics. Where again, we felt that it was already part of a different data class.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Johnny, can you blow your screen up? It's really small, at least on mine.

Johnny Bender – Office of the National Coordinator for Health Information Technology – Back up/ Support
You want me to zoom in, you said?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, if you can somehow, you're – that's getting better, okay. So let's see if I can blow it up. Okay, good. Now back again. Thank you. Just making it easier to read. Okay.

Sasha TerMaat – Epic – Member
It was – we said that about laboratory report narratives and pathology report narratives which were both two note classes that we thought more appropriately belonged within labs.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, let's go back up to 18 or 17 or 16, so right, 15. Now, let's go to 14. So, we are going to change this. So we are not going to accept all clinical notes, we are going to accept the following clinical notes. And we'll list them out. And then we will say we don't want laboratory narrative because it's duplicative, already included in results. And we don't want the pathology narrative because it's duplicative and already in notes.

Sasha TerMaat – Epic – Member
The other one I'll call out is that imaging narrative is probably implicative of what's coming in a future version which is the diagnostic imaging reports. Which is sort of forecasted for USCDI V.3 in the draft thing? And so, if we put imaging notes or imaging narratives in now, we would want to take it out later in V.3 when diagnostic imaging reports are added as a data class.

Alternatively, my suggestion would be taking it out of notes and just add diagnostic imaging reports. Which is seen as quite well adopted, into V.1.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, I like that. So we will – all right. Does that so far, is our adjudication correct? No laboratory, no pathology, and no imaging. And we'll make another recommendation that diagnostic imaging reports be included in USCDI V.1.

Adam Wong – Office of the National Coordinator for Health Information Technology –Back up/ Support
This is Adam. I would not recommend factoring in those emerging in candidate classes that were in that initial draft of the USCDI from a year ago, January, as written in stone. As far as the expected delivery of those as potential USCDI elements.

Sasha TerMaat – Epic – Member
I think we're not taking that as written in stone, we're sort of making a recommendation which is that we think diagnostic imaging reports is actually ready for consideration.

Adam Wong – Office of the National Coordinator for Health Information Technology –Back up/ Support
Okay.

Sasha TerMaat – Epic – Member
Others in the workgroup would want to discuss that further. I think it would be better to work on that than imaging narrative as notes.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And again, ONC can ignore this if they don't like it.

Sasha TerMaat – Epic – Member
Well, they have to address all of the comments they get. We can disagree with them.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. We disagree. Thank you. Next. So they don't have to write a long note. Okay, so tentative care documents, Clem says it's not widely in use. But it actually was the meaningful use workhorse if I recall. Everybody sent continuative care documents because you could check all the meaningful use boxes. I suspect that people do that.

Sasha TerMaat – Epic – Member
I agree they are well adapted as a CCA template but are they really like a note? What is the concept of – part of what I was puzzled with here is when we say we want to adopt these are we saying we want the CCA template to be adopted and supported within the EHR or are we somehow using the CCA template names to refer to different types of notes?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes. Good question. Obviously, it came off the list of CCA templates.

Sasha TerMaat – Epic – Member
Right. If we're really saying we want to propose the adoption of a whole bunch of additional CCA templates, I guess to me that merits further consideration because each of those represents a development effort and I don't know that all of them are of the same priority. If we're saying we just want to adopt additional note types and use that list as an inspiration of what types of standardized notes are there, then I would say continuative care document does not make sense to me as a note type.

Tina Esposito – Advocate Aurora Health – Member
And I was confused because what would a CCA provide that wouldn't already be listed here as a note or other element?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
CCA templates actually provide an outline for the content. Which I guess as I think about it more is my objection to these notes not being included. And this may not be fair, the current system's workflows don't adequately provide the information needed. So maybe circular reasoning there.

Okay, so. So maybe on this whole area, there were a couple of note types that are particularly important for non-medical providers, like the summery transfer note and the – that one in particular. And then, in general, the advanced care plan. I don't know why that's duplicate.

Sasha TerMaat – Epic – Member
When we say, this is just for context. So again thinking about these in USCDI that means they go into a certification requirement. Does every software product then have to support all of USCDI, and then does that mean you just have to support just the receipt of these things or both the generation? If you think of an operative note, a surgical system would want to support the generation of operative note. A family practice/ambulatory care system would just want to support the reading of an operative note but wouldn't be intended for the generation of an operative note in that EHR. That sort of is a level that I feel like was not contemplated by these recommendations but would be important before they are all translated into certification requirements.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, I think we are going to tackle that one in phase two, sort of the advancement process. Because one of the first questions I have on my list is exactly that. Do they apply to everyone or are they sort of role-specific? Generate or support it. You don't, you don't.

Sasha TerMaat – Epic – Member
What does that mean for like 17?

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

Seventeen, inoperative. Yes, it would be exactly what you said. Interior care practice would need to read it but not generate it.

Sasha TerMaat – Epic – Member
I am just worried that it's not clear that that would be how it would be interpreted by ONC when they go to write certification requirements. And they would decide that to support USCDI everyone has to be able to support generating an operative note.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, again, I think that comes in stage two. I think that's what our recommendations would be. So we would – I can't anticipate what we were going to come up with, but my recommendation would be that it is really role specific. And that it's not a global certification requirement, that it is specific to what you do. And if you don't do it, you don't have to support it.

Okay, so I think, unfortunately, we are at the end of the hour. But this is really helpful. Thank you, guys, so much.

Sasha TerMaat – Epic – Member
Do you have any follow up homework for us, Terry? Do we need to put in further comments or respond via email?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
What we'll do is we will send this file out to everybody, and if you want to make comments in the adjudication comment column, that would be great. I am going to take these comments and go back to our transmittal letter and fold them in. But that would be hugely helpful. Because we are probably going to have one more round, hopefully, we get the transmittal letter out this weekend. And hopefully give people a day or two to comment on it, because we have to get it out on Wednesday. So probably Tuesday noon time is going to be the close on comments. But this is really hugely helpful. I think we made great progress. And anyone who wasn't on the call, you know, they had their chance. Anyway.

So, thank you. And so, Adam or Johnny, or Stacy, can we get a copy of this document out to everyone on the task force with the request that they review the adjudications and to comment on the ones we haven't gotten to? If they have something other than the comment they already made.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Sure we can get that out after this call.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Great. Sounds good. Thanks, everybody.

Sasha TerMaat – Epic – Member
Thank you.

Tina Esposito – Advocate Aurora Health – Member
Thank you.

Sasha TerMaat – Epic – Member
Bye.

Tina Esposito – Advocate Aurora Health – Member
Bye.

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