U.S. Core Data for Interoperability Task Force

Transcript
February 28, 2018
Virtual Meeting

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Thank you. Hello everyone and good afternoon. Welcome to the U.S. Core Data for Interoperability Task Force. I want to thank you all for your time today. I know we only have an hour. We have quite a bit to cover. I will call the meeting to order starting with roll call. Christina Caraballo?

Christina Caraballo - Get Real Health - Co-Chair
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Terry O'Malley?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Steven Lane?

Steven Lane – Sutter Health – HITAC Committee Member
Good afternoon.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Clem McDonald?

Clem McDonald – National Library of Medicine – HITAC Committee Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Brett Oliver?

Brett Oliver – Baptist Health – HITAC Committee Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Ken Kawamoto? Do we have Ken on the line? Not yet? Valerie Grey?

Valerie Grey – New York eHealth Collaborate – HITAC Committee Member
Here.
Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Thank you. Laura Heermann Langford?

Laura Heermann Langford – Indiana University – Public Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Leslie Hall?

Leslie Kelly Hall – Healthwise – Public Member
Yes. Leslie Kelly Hall here. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Thank you. Nancy Beavin? Not on the line yet? Kim Nolen? I believe I heard Kim dial in earlier. Kim, are you on the line? Rich Elmore?

Rich Elmore – Allscripts – Public Member
Here. Kim said she was in an airport but on the line.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Thank you. Eric Heflin?

Eric Heflin – Sequoia Project – Public Member
Yes. Eric Heflin is here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Dan Vreeman?

Dan Vreeman – Regenstrief Institute, Inc. – Public Member
Hello. I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office Moderator:
Mike Perretta?

Mike Perretta – Docket – Public Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Rob Havasy?

Rob Havasy – HIMSS – Public Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Okay. With that; Christina, I will turn over to you.

Christina Caraballo - Get Real Health - Co-Chair
Thank you all for joining today. Before we get started, we just wanted to give you guys a couple of quick highlights from a debrief we had with Steve Posnack earlier this week that I think will help us streamline our task at hand and provide more clarity to the task force as we provide recommendations that are needed at this stage in the game for ONC. One of the biggest things that we wanted to relay to the group is that we're looking at defining what is the minimum set of data that's needed on a national scale to help make interoperability work by the most stakeholders. As we were talking to Steve, we went through that this is the USCDI is ONC's next phase in how we're going to progress data as a result of industry feedback post the 2015 edition. There's been a lot of feedback that data's not there when it's needed, and that there's often missing pieces. There's also been a recognition that in order to address this we need to expand the TEFCA and look at data that would be exchangeable agnostic of the exchange process.

The USCDI is really intended to be a very transparent mechanism to really give the industry a head's up about what's coming in the future. It's more of a progression process and needs to be framed even where we have red flags to know what we need to build today or more quickly. Our task force should keep this in mind as we consider how we're going to do our expansion process. Before we move on to the actual data classes that we should consider, we really need to focus our attention on bringing in a good framework and process to evaluate them.

With that said, we really are at the beginning here. This is our eight-week sprint to set that foundation. Steven reminded us as we kind of want to go into different areas that there's a lot more work to be done before the one of the USCDI is going to be published. As part of our high-tech kick-off, there was a section in the Cures that pointed to defining use cases and prioritization and associated standards, which will be a separate task force coming down the pike soon. A lot of the homework we did has helped us to begin to see the broad ecosystem that exists. We have quite a few pages on defining the stakeholders. We intend to put those in what

we're calling our "parking lot," so we can use it in the future.

We've also realized in discussion that we want to move on to our next charge, which is to actually look at the proposed categories to which data classes would be promoted and objective characteristics for proposal for permission. As we work through this, some key things I want the task force Terry and I were talking about, to think about what our minimum national data set needs, how we group and decide between these data classes, how does data actually get on our list, how should ONC incorporate public comment, how do we as an industry really want to engage as ONC manages the USCDI, what has made this data so important that it needs to be in this floor where we said this is the data that has to be available.

How does something get into the USCDI? ONC is looking at emerging and candidate classes and really wants to hold industry accountable for what those are. It's up to use to have a voice and build this framework so that we can start looking at the gaps and what's needed. What are the criteria and characteristics to signal that ONC is ready to move the data classes to the next stage? When would it move from emerging to candidate? What are they key threshold questions that we should ask along the process? Then constantly thinking about what the receiving end would want if they were to query. That's a recap of our conversation with Steve and where we think we should pivot the task force. Before we move onto actually diving into the meeting topics, Terry, did you have anything that you wanted to add to that?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Thank you, Christina, that's great. Only two things. One, the homework was extraordinarily helpful and you guys thought long and hard about whom ought to be stakeholders, and domains that should have a voice in proposing data classes. As Christina said, those are going to go in the parking lot and someone else will find it very useful to drive out there and see what's parked. We're going to get onto the job of defining the criteria; of identifying the criteria in order to prioritize data classes that get you the processes Christina said. In order to define our criteria, we're actually going to have to prioritize our priority criteria. That's going to be our work for the next call or two. Thanks, Christina.

Christina Caraballo - Get Real Health - Co-Chair
I guess we can go ahead and move onto our actual – I can go back one more slide. You know what, I actually think we've talked about all of this so we're good. Just wanted to point out again to think about how we're going to progress from this broad scale identification or the merging data classes to those ready for nationwide scalability looking at how we balance that quantitative, qualitative, and technical criteria considering that all-expansive, all-of-the-above set of criteria versus a small core set. Then, looking at inclusivity, practicality, and equality. One other thing I wanted to point out is that the USCDI is that floor where we're saying all of this data is what is needed for national broad exchange. We have talked about – and I think many people have brought it up – there will be dotted lines to the interoperability standards advisory, which has that full document of all available data standards. We're kind of looking at that and how we take what we're putting in the merging buckets and have links back and forth as well. We can move onto the next slide because we have all of them bucketed here. Here is our prioritization criteria that Terry laid out beautifully for us, bucketing the main overarching things that we should look at, which are the characteristics of the data classes, the characteristics of the stakeholder, characteristics of data management process, characteristics of the domain, and characteristics of the subject population. We went ahead and put a first round brain dump on

this list to get ours started with the discussion amongst the task force.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Christina, let me ask the task force the first question. Any comments on the prioritization categories if we go back one slide, which just breaks up the categories. The question is: Are there others? Is this a reasonable way of doing it? Should we have a different set of buckets for our prioritization categories? This list is essentially a distillation of everything that you all wrote in your comments, or hopefully everything.

Clem McDonald – National Library of Medicine – HITAC Committee Member
This is Clem. I think some of them are a bit intermingled or could be entangled.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
So sorry, Christina and Terry, just want to make sure we're acknowledging the members with our hands raised. I saw Kim **[crosstalk]** hand raised first? I don't know Kim if you no longer have a question or a comment, but I see Laura **[inaudible] [00:12:28]**.

Kim Nolen – Pfizer – Public Member
Hi, this is Kim. Sorry. I'm in an airport so I hope it's not too loud. Do you hear me okay?

Christina Caraballo - Get Real Health - Co-Chair
Yes. We can hear you.

Kim Nolen – Pfizer – Public Member
I was raising my hand on the **[inaudible]** with a couple of comments that I wanted to make on those. If you want me to wait until we get to that slide, I can.

Christina Caraballo - Get Real Health - Co-Chair
No. Go ahead.

Kim Nolen – Pfizer – Public Member
Okay. Some of the things when I went back and I listened to the recording and went through all the homework documents and everything. When I looked at the characteristics of the data class, some of the things that stood out to me is: in the draft document, it has whether it's in FHIR or in the consolidated CDA but it doesn't talk about if it's structured with vocabulary, or if it's like a text. I was wondering if that could be a characteristic of the data class because if it's really high-value and of high importance, even if it's unstructured, we may want to figure out a way to get it more structured. I was looking at the goals and the assessment and plan of treatment. I'm not familiar with those being structured and having that clear vocabulary but I'm not attached to those either. I may just not know about it or health concerns. I think knowing that that has a vocabulary and if it's structured would be a good characteristic. For the stakeholders, I think one group that's missing is pharmaceuticals. I would ask that that be added into it. I'm sorry; I do not understand the characteristics of the domain so I was wondering if somebody could explain that to us to make sure we're looking at it the right way. I'll pause and go on mute because I have a lot of background noise.

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

I'll take that one since I was the one who made these very arbitrary buckets. It's just to get a sense of the overall different domains the stakeholders will meet. We probably had about 40 that you all came up with. The question is: How do we tell them apart? Are there any characteristics about these 40 potential sources of data classes that we might want to consider as a prioritization criteria? It affects a high-volume of patients, it affects a lot of money, or it's an affecter that has a lot of failures we really need to address. That's where those arbitrary categories came from.

Kim Nolen – Pfizer – Public Member
Would it be like a risk stratification tool we've used?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
I haven't thought of it so much as a risk stratification tool as it is a potential criteria that we might use to advance one data class over another. If a data class addresses the needs of a domain for a big chunk of healthcare dollars and didn't seem to be doing very well that we might – if we chose those as criteria that would advance that data class, we might say; okay, it checks off three of those boxes. Do we want any of these to be on a list of how we decide what data classes we want to advance along the ONC pass way?

Kim Nolen – Pfizer – Public Member
Okay. I think I understand that now. One other thing with the data classes. Will there be some hierarchy with them? Demographics? They have patient name, date of birth, gender, sex, preferred language, and ethnicity. You have demographics and all of those things fall underneath have specific data classes, like patient name, that it's really part of a demographics. If that makes sense.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
I think what we're going to do on the first several rounds is not worry about exactly what's in the data classes and instead worry about how we're going to choose among them. You already raised a couple of potential criteria, like the fact that there's a standardized vocabulary even if there are not semantic standards or structure around the information. The questions you raise are going to be important at some point, but that some point is sort of down the road. Our next task is really to figure out how we're going to justify one of us saying that this is the most important data class in the world. How would I justify that to you in a way that made sense? That's sort of the perspective we're taking on this.

Christina Caraballo - Get Real Health - Co-Chair
I see we have several other members with comments. Should we go to Laura next?

Laura Heermann Langford – Indian University – Public Member
This is Laura. Thank you. I kind of have the same issue that I think Clem had – that they weren't terribly exclusive with each other. I think I can deal with that grayness. I was also very confused by the characteristics of the domain. The discussion that just passed helped with that. I think it will still clarify as time goes on. I just wasn't sure what kind of mindset I was supposed to have when he would say the word "domain." I think I'm getting it now. Thank you very much.

Clem McDonald – National Library of Medicine – HITAC Committee Member
I've got a couple of things. I don't think you've distinguished between these domains'

dimensions well enough. I think you need an example or two. I think class and the domain and pretty convolved as well as stakeholders. If you call the class pharmacy then the stakeholders will be the pharmacists and the clinicians. I think there are too many dimensions, quite frankly. We should be sharper in the distinctions or we'll trip all over ourselves. Also, I don't think we should be talking about patient registration data because that's done as far as I understand. This is talking about the next step, right? At least get that clear.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Clem, let me ask a clarifying question. You would suggest that we identify a class of domains, and you gave pharmacy as an example. **[Crosstalk]**

Clem McDonald – National Library of Medicine – HITAC Committee Member
I'm only saying they overlap a lot. There are no examples here to be sure what you're really talking about. If you say "medicines," lots of stakeholders are going to be **[inaudible] [00:20:45]**. What's the domain? What's the difference between classes of content in a domain?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
That's the lack of clarity. I see. We've been using domain and stakeholder interchangeably to identify groups of entities or individuals who have a reason to want a data class advanced because it is of high value to them. We're just trying to identify who's got a reasonable voice to put forward data classes. There's nothing fancier than that. It's just a list of all of the potential people.

Clem McDonald – National Library of Medicine – HITAC Committee Member
You've got stakeholder and domain as separate, too. I thought I just heard you combining them.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Okay. That's a good thought. Good idea. This is a work in process, so thank you.

Clem McDonald – National Library of Medicine – HITAC Committee Member
I think of domain as being a kind of data and classes as a sort of data because data can have high volume, high costs, and high failure rates. Data classes can be important. It can have easier standardization so I think the stakeholder is "clearish." If nobody else has trouble with that, I don't care. I'll be quiet.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Thanks for the comment. We're going to keep rolling ahead and circle back.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Valerie, I think you're next with your hand up.

Valerie Grey – New York eHealth Collaborate – HITAC Committee Member
Great. Thanks. I had one question and then a comment. Under the characteristics of the stakeholder, the bullet that talks about contributes to a valued health outcome – is that the bullet that would apply to community-based organizations in some of the non-traditional clinical providers that are more and more part of the care teams going forward?

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

That was my thinking. Yes. What we're trying to do is to get away from sort of the first bucket of what the data class looks like because a lot of the really mature data classes are there for a pretty restricted, although important, group of users. The meaningful use, all triple provider group as the poster child. To get to the folks that really haven't been part of that process and don't have a mature set of data standards, but contribute to an important outcome. It's just a way to get them in queue.

Valerie Grey – New York eHealth Collaborate – HITAC Committee Member

I think that's extremely important and it's definitely a direct a lot of I think the HIEs are headed in. I understand a lot of the conversation about different overlaps, but when I took a look at the data management process I wondered if in addition to cost and availability, do we need to think about the quality of the data? Or maybe that's sort of captured in the characteristics of the data class. I just know from experience here in New York that we've got a lot of data coming into the HIE – it's in a standard format, but often times we have issues with the quality of the data and, it is, in my opinion, a really important part of the mix when we determine our priorities here. I just wanted to throw that in.

Christina Caraballo - Get Real Health - Co-Chair

I think that's definitely an area that's really important to capture. Rob?

Rob Havasy – HIMSS – Public Member

I think Valerie just touched on the area that I was going to look at. The overwhelming early feedback that we've heard is that many current exchanges are nervous that these requirements are going to completely disrupt existing business models. I thought it was important that somewhere in here, as far as stakeholders and other people we mentioned here, that we give currently exchanged data some kind of priority. I know we mentioned data that's currently being collected as a characteristic of the class. I know we mention availability in data management process, but if there are things that are already being actively exchanged I think it would go a long way to giving that community a voice here if we give some priority to those things that develop organically. If the market is speaking and people are able to collect and exchange data and find value in it, we ought to look there and recognize it I think. Between that and one way or another, formally looking towards existing health information exchanges as a stakeholder. To make sure that that voice is heard I think would go a long way towards smoothing the implementation and the maturing of this system in general.

Christina Caraballo - Get Real Health - Co-Chair

Rob, that's an excellent point. It'd be great to know where you kind of put that. We want to make it really clear that there are lots of voices saying I need this and this is the most important thing to me to make interoperability work. Our task at hand is: How do we get the data that's needed at the national level for the most people and where are those gaps? How do put what you were just saying into the criteria for us to evaluate so that ONC can look at this and look at the emerging data classes and say; what's got the most traction? What has the most points so that we can say that's the next thing that's ready and it's going to impact the most stakeholders? As we go through this, we've also talked an aside about how many some of these things will be weighted, or how we're looking at it. It's really important right now to capture exactly what you just said. If we can look at where in the framework we would put that, it would be helpful.

Rob Havasy – HIMSS – Public Member
Here's the way it's starting to collect in my mind. Emerging data classes are more about need and value. That's where we look and say, somebody wants this, somebody needs this, impact the high cost or some of the other criteria, high volume domain. For promotion from emerging to candidate is where we have to start looking at reality. That's where some of the stuff that Valerie touched on is important. That's the time I think where we need to ask the exchange community; okay, we think we want this. It's an emerging data class people. People want it. Can we do it? I think there's a – I don't know what we want to call it – subtask force or survey we do to ask the current exchange community to say; what are those criteria you look at? So we can say, are there mature standards? Valerie just brought up a great point. Are those mature standards actually implanted in a uniform way? There may be that second level that we need to look at when we get the candidate status and think about promotion from candidate to the CDI itself where we say okay, can we really exchange this? Are the standards well implemented? Is the vocabulary well established and widely used? Et cetera. Does that make sense?

Christina Caraballo - Get Real Health - Co-Chair
Yes. We've got a lot of hands up so we're going to move onto Daniel. You're up next.

Dan Vreeman – Regenstrief Institute, Inc. – Public Member
Thanks. I'll just echo other comments saying that the domain label too has confused me. A big part of it is that we're not all refereeing a common information model, so it's tricky. I think the characteristics are fine, I just don't know if I would label that as a domain or not. I'll leave that aside and then you consider the idea of how the data class **[inaudible] [00:29:51]** for these characteristics. The first is, I think it'd be helpful to have a characteristic that describes the breadth of content captured, or intended to be captured, by this class. Going along with that, the precision of the definition of the class. One of the things I struggle with is you have little itty-bitty things when essentially a data class is ultimately one variable. Then you have others where it's the entire domain of all laboratory tests. Those are completely different scales of complexity. It relates to the standardization, but I think a sort of more precise honing of being able to define what goes in that class and how wide is the scope of it would be useful for distinguishing and prioritizing.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Did you think there is a criteria or two buried in what you just said around data classes? Is it a good thing to be narrow or good thing to be broad? Is the next level down that it's a good thing to be structured or unstructured? Is it a good thing to be tied to standards or standardized vocabulary? And so on down the layers. There may be multiple layers. But is that sort of where you're heading?

Dan Vreeman – Regenstrief Institute, Inc. – Public Member
I think it's useful to lay it out and say that these are characteristics, so it's combined with the other dimensions as to whether you would think it's a good thing or not. Lot of small things that are easy to standardize. Okay, we might want to do that. Only one thing, but gosh, it's really hard. Maybe we set that aside. It's more like a descriptor that is a characteristic upon which you would make your overall assessment to prioritize up or down.

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

Great. That's very helpful.

Christina Caraballo - Get Real Health - Co-Chair
Eric. Go ahead.

Eric Heflin – Sequoia Project – Public Member
Thank you. Just a couple very quick comments. One is really from the Sequoia perspective. One of the things we would look at is the testability of a given criteria. It immediately struck me as being very difficult to test. Two, and I really think this should be use-case driven, and so one of my hopes is that the criteria are actually not really decided to the series of meetings so much as we have an initial overall process to find, and initial attempt to define the criteria and the data sets **[inaudible] [00:33:05]** but that the actual work is really facilitated by the RCE and it includes broad stakeholder prioritization and **tee back** and ultimately that results in this being driven by use cases by I think were mentioned earlier in this call. I believe that's critically important so this is actually not a technology based process, it's actually a process whereby which we have a list of broadly vetted and prioritized use cases which then drive everything else and not the other way around. Otherwise we can be in a situation by which we don't know if we've got it right or not because we have no way of judging our work in this task force. The final criteria I'd like to suggest. I believe there's actually a curation of the value set that we can point to. In my cases where that curation exists, such as HE or HL7 or other **[inaudible].** The sierra body itself has in some cases their own assessment process where they determine the maturity of the associated data. I wanted to also thank one of our Sequoia staff members, **Andy Davis**, who was a real driver of international content **[inaudible]** really contributed a lot of the feedback we've been providing. That's it.

Christina Caraballo - Get Real Health - Co-Chair
Thank you, Eric. Moving on to our next commenter. Steven, go ahead.

Steven Lane – Sutter Health – HITAC Committee
I had a suggestion under the characteristics of the subject population. We didn't capture underserved. While I think most underserved populations are high risk, it might be worth calling that out independently. I also wanted to ask Terry to say a little bit more about what you mean by characteristics of the data management process. We've discussed some of the other categories but I don't quite get what you're after there, or what you've included.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Remember, this was an initial stab late at night to get some of these categories done, so I'm not wedded to any of them. I was just trying to get at the point that some days the classes are easier to get than others for a variety of reasons. Some are part of workloads, some aren't. Some are very specialized. Some are not. It's really to get a sense if there are any criteria buried in the process needed to pull that nugget out and send it along? Is there anything in the criteria? Should we have a criteria that bears on that part of the process? Or is it so much part of all the other pieces so that we can just ignore it?

Steven Lane – Sutter Health – HITAC Committee
When you say availability and cost, you're referring to the availability of the data and the cost of the getting at it, is that right?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Right. Correct.

Steven Lane – Sutter Health – HITAC Committee
That was what I just wasn't understanding.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
That may be buried under the characteristics of the data class and not need to be broken out, but it's the shortest subclass so I'm happy to drop it.

Christina Caraballo - Get Real Health - Co-Chair
Leslie?

Leslie Kelly Hall – Healthwise – Public Member
Thank you. I think wherever we capture, perhaps in the data management process; usability might be a good criteria to help determine whether that data is ready to move to the candidate status. Back to our very original message and mantra. We talk about parity and that all things are equal for stakeholders. I want to make sure we have a way to, when we're talking about cost; we're not just talking about cost of the health system if a patient is involved. Perhaps they are high cost to them. Making sure that our characteristics of any decision making goes back to the principles of parity so that we have a way to continue to evaluate given the patient's voice and not just the overall health system in general. There's nothing here about urgency of data of the data class. I think that could help us to understand that this is something that needs to be done right now. Are decisions being made or is this something for historical review? Some sense of urgency included in our characteristics. Thank you.

Christina Caraballo - Get Real Health - Co-Chair
Thank you, Leslie. We have a lot of hands up so we'll address the comments later and circulate to the task force. Kim, you're next.

Kim Nolen – Pfizer – Public Member
I was just looking through my notes and one other thing that I had put on for maybe a characteristic at the **[inaudible] [00:38:58]** cause. Is it part of the current certification process? That may help us in understanding how widely it's already implemented. I just want to agree with what Valerie said about the data quality and what the end **[inaudible].** I thought the different classes, that's what I was trying to get to with the demographics, that we have specific things that are demographics that when you look at medications and procedures, they are very much granular within those separates that's why I was asking about that hierarchy. I think that's it. Thanks.

Christina Caraballo - Get Real Health - Co-Chair
Thank you, Kim. Clem?

Clem McDonald – National Library of Medicine – HITAC Committee Member
Yes. There are two or three things. One of them I think the quality will get better if we clean our standardizations. For a lot of stuff the problem is they don't have the codes in them. They're not lined up. I'd like to get some examples because I kind of hear this thread that we really should be looking at stuff that's not wanted by the healthcare system so much. Who doesn't want

drugs? I'm not talking about drug abuse. What community – whether they're patients or community health centers – doesn't want information about drugs? Please give me some counter examples. I think the same will be true for x-ray tests and other kinds of tests. If you're a patient, you want to know it. If you're a disadvantaged person, somebody around you needs to know it. Tell me if I'm wrong on that.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Clem, this is Terry. An example might be from the home and community based service end of things, which is not so much medical as it is dealing with function and filling in gaps between what the environment requires of an individual and what the individual is able to do on their own. They probably don't really need to know what your medication list is unless they're part of a process to be surveillance for that. They're more about having a change in function, a change in living situation. Their data needs are important. The reason this group is important is that for the high risk, high cost, elderly patients who drive about 50 percent of the Medicare healthcare dollar, these services are critical to keeping them at home and out of the rest of the healthcare system. There's an example **[crosstalk].**

Clem McDonald – National Library of Medicine – HITAC Committee Member
I don't disagree that other items are valued, but if someone's worried about someone being homebound and they've fallen down, it may be because of their medication. This separation it's really almost like **prejudicial.** There are these two different categories and they compete with each other. They all meet all of it. My opinion.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
What criteria would you like to put forward?

Clem McDonald – National Library of Medicine – HITAC Committee Member
A practicality because we're going to be trying to drink the ocean, or boil the ocean, and we're not going to get it all done. I've been working on this for 20 years and we haven't gotten that much done yet. I think we've got to really pick things that we can get done in somebody's lifetime and be careful about the things that require remodeling the whole system, and tackle the things that are lower-hanging fruits. Not to exclude the others, but realize you can get more bang for the buck sooner if we tackle stuff that's half-baked. We just have to finally get it cooked. There is a big problem of remodeling the system. I hope you all know that. If you get everybody to behave differently, it's to put in new kinds of data, that'll take awhile. It's okay to go for it; it's just not going to be as immediate.

Christina Caraballo - Get Real Health - Co-Chair
Thank you, Clem. Terry, did you have something?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Nope.

Christina Caraballo - Get Real Health - Co-Chair
I'm going to move onto the next comment. Nancy? Nancy, we can't hear you. There you go.

Laura Heermann Langford – Indian University – Public Member
Sorry, that's me, Laura. I was just going to say; maybe we could just go to Leslie then come back

to Nancy.

Leslie Kelly Hall – Healthwise – Public Member
Thanks. Yes. I'd like to echo Kim's earlier comments about the narrative and making sure that we don't standardize that out because the narrative is still important in making sure that part of the criteria – you don't want to eliminate things because they only meet very specific conditions. Also, based on Clem's comment, perhaps in our structure we have classifications that understand we're not going to do the emerging today, but we are going to consider an emerging area to keep that list going, whether it's a parking lot list or we choose one per year. We're not always looking at the here and now but have an opportunity for a process to include emerging including things like patient-generated health data, which today would not meet any of these criteria, yet could be very, very important to efficiencies in healthcare. Thank you.

Christina Caraballo - Get Real Health - Co-Chair
Eric.

Eric Heflin – Sequoia Project – Public Member
Just one final brief comment to elaborate. One criteria. I think these also include the fact the data is non-static. Value sets are far from static. They change frequently. One criteria I think should include that there be – not like criteria for selecting but also for the broader process there needs to be some type of mechanism for acknowledging the data. The value sets. The **good** systems as they evolve over time. Thank you.

Christina Caraballo - Get Real Health - Co-Chair
Lauren, did we need to move to a public comment now, or do we have time for more discussion?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Yes, we have about five minutes left of discussion if you have additional slides. We'll go to public comment. If there are no public comments, we can certainly use the last five minutes for additional discussion.

Christina Caraballo - Get Real Health - Co-Chair
Terry, did you have anything that you wanted to bring up? I don't see any more hands up.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
No. I think that was a great discussion. Were there people who didn't say anything that we should call on for their comments?

Nancy Beavin – Humana – Public Member
Anyone able to hear me now?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Yes. We can hear you. That's right, we forgot to come back to you.

Nancy Beavin – Humana – Public Member
No, that's okay. I was struggling with my audio. I just wanted to add a little bit to the

conversation of the data integrity, data quality, and maybe add the word data completeness. As we continue to exchange data with the CCDA and we get a lot of good structured data and we know a lot about problems and medications and labs. Being able to put that together with the **[inaudible].** I know others have mentioned this early on, but that somewhat unstructured data and being able to get a complete medical record in the exchange of data, is really critical to folks like payers and providers who are trying to do continuity of care. I just wanted to add that concept a little bit to the whole concept of data quality and data integrity. Today we for the most part don't get a complete medical record. That's really from my perspective what we need to hopefully be striving for.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Christina, this is Lauren. I didn't realize we had planned the public comment at 4:20 p.m. Maybe we can stop for public comment now. I see you have additional agenda items if that works.

Christina Caraballo - Get Real Health - Co-Chair
Sounds good.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Operator, could you please open a line for public comments?

Operator
Sure. If you'd like to make a public comment, please press star one on your telephone keypad and a confirmation tone will indicate you're in line as in the question queue. You may press star two if you'd 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 Office
Just as a reminder, we'd like to ask everyone to keep his or her comments to no longer than three minutes. Operator, do we have any comments in the queue?

Operator
Yes, we do. Our first comment is coming from Robert **Heiselman**.

Robert Heiselman
Hi, can you hear me?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Yes, we can hear you.

Robert Heiselman
I just want to comment that I think the work that you're doing is excellent. It's much needed. I wear two hats in my organization. I see patients half of the time, and I'm also a clinical informaticist. I kind of crashed your party and invited myself but I would certainly be willing to attempt to bring a clinical point of view to the conversation and I've included some of my

comments in the chat. Thank you for having me. I think it's important to have members of the public involved in your process. Thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Operator, do we have another comment?

Operator
Yes, we have another comment coming from **Larry Wolf.**

Larry Wolf
Hi, sorry, Wolf. I'm chief transformation officer at Matrix Care and wanted to let you know that some of the world is listening in on these deliberations and I'm really glad to see the depths of conversation about what the criteria should be around the data elements. They're identifying what's currently in play building on the criteria and taking that forward and giving the long window of heads up of things in consideration is a very effective way to engage industry and providers and advance of things being locked down. I'm particularly interested in where you wind up taking the provenance piece which is sort of right on the cusp of an addition that's being proposed in this next round of capabilities. I think it's both a very important area that we should start to move forward on and I could see where it could present some challenges as well. Thanks for the good work and looking forward to seeing it continue.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Thank you, Larry. Operator, do we have another comment in the queue?

Operator
No additional comments at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Okay, thank you. Christina, I will turn it over back to you.

Christina Caraballo - Get Real Health - Co-Chair
Great. Thanks. I guess we can go ahead and go to the next slide. For those on the task force attending HIMSS next week, Rob Havasy has reserved a conference room for us to convene in that holds about 20 people. All task force web members are welcome to come join us in that meeting. We will circulate that.

Clem McDonald – National Library of Medicine – HITAC Committee Member
Will there be a dial in? Because I won't be at the HIMSS.

Christina Caraballo - Get Real Health - Co-Chair
Yes, everything else will remain the same. WE just realized that we needed a quiet place and didn't want to cancel next week's meting so Rob kindly offered us a space at the HIMSS conference for those of us to escape the madness of the floor. That will be there.

Clem McDonald – National Library of Medicine – HITAC Committee Member

Okay, thanks.

Christina Caraballo - Get Real Health - Co-Chair
All else is normal. If we don't have anything from anybody else that anybody would like to add, I think we can move on to the next slide. Do we have another? We actually do not – we have some reference materials the very last slide we wanted to put on people's radar but I do not think we have anything else now unless Terry, you want to add anything? We'll be circulating, chatting, and circulating some more homework for next week's call probably within the next day or two.

Terry O'Malley - Massachusetts General Hospital - Co-Chair
I think the homework – just a spoiler alert – is going to be slide five or whatever the prioritization criteria and ask you to look at them with a perspective of what are these criteria would I use to justify my claim that my data class is the most important data class in the world? Think about ONC getting 10,000 comments on what's the most important next piece of data to be around and how we can help them plow through their 10,000 comments. That'll be the context in which we ask you to go through the prioritization criteria.

Clem McDonald – National Library of Medicine – HITAC Committee Member
Is there any thought about balancing multiple criteria's? You're going to have criteria, but which one wins? Which trumps what? Any thoughts about that?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
We're waiting for all your thoughts. Propose it. It's going to be a very interesting process; I have no idea how we're going to come out.

Christina Caraballo - Get Real Health - Co-Chair
If we're going about this the wrong way now then I think we can also reset. We love comments. Feel free to send emails of how we should go about creating this framework. We're at the very beginning stages. We can shift what we're doing and I think we're very open and flexible to be able to do that. **[Crosstalk]**

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
This is Lauren just calling to acknowledge. I know we have one more comment it looks like from Leslie. Just wanted to make sure we acknowledge that before we adjourn since we still have a couple minutes left.

Leslie Kelly Hall – Healthwise – Public Member
I sent in the comment to Adam. I think I'm set, thank you.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Okay, thank you.

Clem McDonald – National Library of Medicine – HITAC Committee Member
One little one. I don't know if everyone is aware of what this current state is. The thing was

presented as in what's new, and I heard stuff discussed which is pretty far along already. Is there some value in just sort of presenting what you think is kind of **[inaudible] [00:55:23]** well along?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Interesting thought. Absolutely. Add it to the queue. Thanks.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Christina or Terry, any last thoughts or comments before we close?

Terry O'Malley - Massachusetts General Hospital - Co-Chair
Thank you all again. This was really helpful and we're reliant on you guys, so keep it up.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Office
Thank you. And just as a reminder, if you were not able to submit or provide your public comments by phone we do have an email address you can submit your public comments to. Thank you and we look forward to having you join us next week, March 7th. For the next U.S. USCDI task force. And we will adjourn.

[End of Audio]

Duration: 57 minutes