U.S. Core Data for Interoperability Task Force

Transcript
March 25, 2019
Virtual Meeting

Members/Speakers

Name	Organization	Organization Type
Christina Caraballo	Audacious Inquiry	Co-Chair
Terrence O'Malley	Massachusetts General Hospital	Co-Chair
Tina Esposito	Advocate Aurora Healthcare	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	ONC	Designated Federal Officer
Stacy Perchem	ONC	Staff Lead
Adam Wong	ONC	Back Up/ Support
Johnny Bender	ONC	SME

Operator
Thank you. All lines are now bridged.

Lauren Richie – ONC – Designated Federal Officer
Good afternoon, everyone. Welcome to the USCDI Task Force under the HITAC. Welcome to today's meeting. We will call the meeting to order, starting with roll call. Christina Caraballo?

Christina Caraballo – Audacious Inquiry – Co-Chair
I'm here.

Lauren Richie – ONC – Designated Federal Officer
Terry O'Malley?

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

Lauren Richie – ONC – Designated Federal Officer
Steven Lane? He might still be out. Brett Oliver? Not yet. Sheryl Turney?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Present.

Lauren Richie – ONC – Designated Federal Officer
Thank you. Les Lenert? Ken Kawamoto? Clem McDonald? Valerie Grey said she would be absent, I believe. Tina Esposito? And, Steve Ready?

Steve Ready – Norton Healthcare – Member
Present.

Lauren Richie – ONC – Designated Federal Officer
Great. Okay, I'll turn it over to Christina to get us started with a quick review of the workgroup schedule.

Christina Caraballo – Audacious Inquiry – Co-Chair
Great. Thanks, Lauren. So, we are going to look at our revised schedule, discuss HITAC review, and – okay, we'll go right into work plans. So, just so everybody's aware, we have pushed up our final recommendations to April 25th. Originally – I can't remember the original date, but that's just a few weeks away. So, in order to make this deadline of the 25th, we are going to move our meetings to weekly, and we would like to propose this time – so, Monday at 1:30 Eastern – for the next few weeks. So, please let us know if that doesn't work, and if we're good, then that's going to be our new regular occurring meeting.

So, then, the next thing that we're going to look at is discussing the meeting from last week's HITAC discussion, and then go into some additional discussion on the clinical notes section. So, a little bit of

feedback from the HITAC meeting: Our recommendations were really well received for patient demographics. A couple things that we wanted to just draw people's attention to – we got more thumbs up on that and moved through it pretty quickly. One thing of note is that the secondary attributes that we are looking at with the patient demographic got really positive feedback as valuable to facilitate some downstream matching, so that was good.

The other highlight was that the use of personal identification, such as Social Security number, might dissuade some people from seeking care, so we just wanted to reiterate that as we go through this process, it's about what we are able to collect electronically and what is available, and we want to try to get as much information as we can. It doesn't mean that it has to be collected.

So, before going into the overview on provenance, does anybody have anything on patient demographics that they wanted to bring up post our HITAC meeting or discuss? I see no hands up, so I think we are good to move forward with our discussion on patient demographics until we've got our draft recommendations ready for the group to present – to present to the group, sorry.

So, the second part that we looked at was presenting our initial recommendations on provenance. As can be expected, this was a really lively discussion, specifically around determining who the author is and what that actually looks like. A couple key things that I wanted to pull – so, this discussion was about the general sense that this is going to be extremely complex and that we really need to figure out how to streamline and tailor what we're doing so that it doesn't become too complicated. I'm just looking at my notes here…

One thing that was mentioned by one of the HITAC members was the idea of having implementation guides and/or use cases to start walking through provenance. Because it can get so complex, if we start with a specific use case, then we can gradually build out the data elements under the provenance data class, which is one area that I would like to discuss in more detail with this group. Let's see… Sorry, guys.

The other highlights – sorry, I just completely lost my headphones. The other area of discussion was around the trustworthiness of the data, and again, this was an area that – this was on our team of trust that people might recall from our recommendations. This was another area that we got feedback that it can be very complex, and where would we start to strike the balance of what is valuable, and what we can gather now, and not impede progress. So, I'm going to stop there and see if anybody else had any additional highlights from the HITAC meeting that they would like to add.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Christina, this is Terry. I just have a question for Sheryl and Steve. Does this still sound like it's on the right track given the shift of focus for elements that are meaningful, currently available, currently…find out what those are and move to the secondary group of things that are meaningful and valuable, but may not be immediately available. Does that approach still resonate?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

This is Sheryl. I think it does. I think the difficulty, though, is that obviously, with some of these, there are two parts to this coin. They are what data is available and what's the dataset that's going to be required to be shared. Of course, on the data provenance question, I think that's what I would call metadata about the data that's being shared, and so, there will need to be some standards applied to how we share that, and I think in this group, we were not all seeing that data provenance information similarly. I think the physicians were looking at it from the perspectives of the person who entered the data and the payer. I was looking at it from the perspective of the entity who last updated the data.

So, we have to understand what level of granularity and things like that can bog this down, so we should probably make some recommendations related to the need for the standard and the need for – clearly, the message we got at HITAC was that simpler is better in order to get something moving, and then expand over time. So, maybe words like whatever recommendations we make shouldn't impede the progress so that the metadata, if you will, about the data in terms of data provenance allows the user of the data to see if multiple updates have been made to the data and other things like that that would enable the support of blockchain and things of that nature. I don't know the exact right way to word it, but to me, that's going to be the magic of what we do here.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. To borrow a page from Steven Lane's handbook, would you like to try to take a stab at a couple of sentences that pull those thoughts together? I agree with you that it's a fine line. The other issue that it raises in my mind is going back – there has to be a lot of overlap between the provenance items that are valued by clinicians, entities, and payers. It's a Venn diagram, so there's going to be a core set that is highly valuable to everybody. Perhaps one of our tasks might be to identify that Venn diagram. The use cases for each are very similar in the sense that you really want to know where the data came from, who touched it last if they did anything to it… Those are really the two major issues, in my mind. Anyway, Sheryl, if you'd like to write something, please feel free.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I'll see what I can put together and send myself my comments on that. I'm not the one to do the Venn diagram because I'm not sure I can visualize what you're talking about, so maybe you're better at submitting that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. I'll think about the Venn diagram. From my perspective, the trouble is making sure each one of the circles doesn't have too many things in it, but anyway…by all means. Sorry, Christina.

Christina Caraballo – Audacious Inquiry – Co-Chair
No, you're good. I like the idea of the Venn diagram, and I think that would support a lot of the feedback we got to start with the use cases and build out, and then it would give us logic to explain that approach.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Steve, do you have anything to add to this?

Steve Ready – Norton Healthcare – Member
No, I agree with what Sheryl said. I also think engaging and finding out the capabilities, hearing from the major EHR vendors with regard to how those standards can be drafted from an architectural perspective – when you look at the Cerners and you look at the Epics, some of the smaller EHRs – to forklift the architecture to be able to produce these discrete elements is going to be more difficult than others for the different EHR vendors, so getting their input is going to be key to developing those standards. That's the only thought I have.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
That's a very good point.

Christina Caraballo – Audacious Inquiry – Co-Chair
Any other thoughts around our HITAC discussion or moving on to next steps on provenance? What are people's thoughts on sticking with our recommendations to the author's timestamp and author's organization, which are the ones that are proposed in the current draft, versus adding additional data elements that we proposed after feedback from the HITAC? So, to jog people's memories, we had a bucket to add unique identifiers, and we specifically referenced as examples the original ID of the data, supplemental ID, Medicare code, and the national provider identifier. I remember from the discussion that the MPI got a thumbs up from a HITAC member who said of course we should do that. So, what are people's thoughts on moving to include other data elements?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Christina, out of a comment born of ignorance of what happened last week, in my mind, I'm wondering whether "author" is really the inclusive term that we're looking for. It's almost the generator of the data. Data can be an image or a test result as well as a text blob. So, is it really "author," or is it sort of the source of whatever that data are? I don't want to take us down a rabbit hole if we've already gone down that one.

Christina Caraballo – Audacious Inquiry – Co-Chair
No, that's a good point.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. What I was talking about in my comment is that I do think we were talking about two different things. Some of us were talking about source and some of us were talking about actual authors. I think there were some concerns expressed that the more data elements we had, the more complex we would make it, and so, would that delay the ability to actually have these data elements available? So, I do think what we should probably do is identify the world – which is the word that I'm going to try to send you – of these data elements that we talked about. Making some combination of these available immediately is going to be necessary in order to validate the data provenance, and then, maturing these over time with pilots and experience and standards will be the way we should move forward because even with the data elements that were discussed, a source could be someone other than a provider who doesn't have an MPI.

Steve Ready – Norton Healthcare – Member

This is Steve. I have a question for you. Are you all defining sources in the future as Fitbits and things like that? Is that considered a source?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I don't know if the Fitbit would be the source or whoever aggregates the data would be the source. And, that might be – I mentioned something like the groups that aggregate social determinants of health data, like LexisNexis. They would be the source, but they've collected the data from a variety of places, so what are we looking at in terms of the source – the one who's providing the data or who they originally gathered it from? I don't know the right answer to that. I asked the question, but I don't think anyone answered it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, it sounds like competing use cases, in a sense, because both answers are valid depending on who you are. So, from the aggregator's standpoint, you'd like to know what the actual source of the data is, and once it's aggregated, in a sense, you're creating new data, and you become the source because the data is now the aggregated dataset of all the Fitbit stuff that you got rather than each individual Fitbit data element.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Right. I'm seeing "source" the same way you are – the one who actually provides the data to the next person in the chain would be the source, because that way, you can always trace back who you got the data from. So, in this example, if I went to LexisNexis and there was a question about the data, then they'd have to identify who they got all that data from. But, to provide the chain that goes all the way back could basically become an information kludge that could become too massive to support. So, when you really look at it, how would you manage this so that the data still becomes manageable to exchange without the taglines for data provenance becoming bigger than the data itself?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Which they will be. That was a concern I had, too. Does every data element need a unique identifier?

Steve Ready – Norton Healthcare – Member
From a **[inaudible] [00:19:23]** perspective, does it become unmanageable to scale that high and that fast with that amount of data and discrete elements?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I would vote against that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, me too. But, is that the logical extension of detailed provenance? So, what level do we need the provenance to start and what utility is it going to have to us as the end users?

Steve Ready – Norton Healthcare – Member
It's what's most important at that moment of the patient encounter, what's most important to the clinician.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
So, imagine that in the future – and again, this is probably too much information too soon – they're trying to decide whether to prescribe an opioid, and they're using social determinants of health data in the background to figure out whether this person is likely to be an abuser. So, the provenance of that data for the physician who's trying to make the decision – he probably just needs to know that all that data was collected by LexisNexis, and now it's in his system. The EHR system may need to know that so that they can validate that it's a proper actor, but at the end of the day, when it comes down to the decision-making regarding using that data, what do you really need to know? You need to know you got it from the trusted source, who's the one that supplied that data to your EHR system.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I like the concept of stages of data exchange, and as long as you, as the receiver of the data, know where it came from then you can pass that with its own modifications on to the next user, who in turn will know who you are and be able to go back to you and ask you where you got it from, in which case you'd go back to LexisNexis and ask them where they got it from, further down the chain. The data itself… I'm just trying to think of a different way of touching provenance without – to Steve's point – making the provenance greater than the data itself. Can we parse it into steps?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I agree with that.

Steve Ready – Norton Healthcare – Member
Just so I'm understanding where your heads are at, should these validations of discrete origins of data – are these done in an automated fashion within the EHRs? Is that the vision you all are seeing? It's not manual. This is going to be **[inaudible] [00:22:40]**, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, I would think that every data element that spits out from the original source would spit out with a sort of ID code – the source, the date – and that's the timestamp for that data element.

Steve Ready – Norton Healthcare – Member
Again, back to my earlier point, having the EHRs' input on how this is facilitated through web services and APIs will be critical.

Christina Caraballo – Audacious Inquiry – Co-Chair
Terry, I do like your proposal of using the term "source." What are other people's thoughts on "source" versus "author"?

Steve Ready – Norton Healthcare – Member
I like it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
We know Sheryl does. One of the advantages of the small group is that the four of us can agree on whatever we want.

Christina Caraballo – Audacious Inquiry – Co-Chair
Any other thoughts on provenance?

Steve Ready – Norton Healthcare – Member
Not from me.

Christina Caraballo – Audacious Inquiry – Co-Chair
Steven, one of the things you brought up was – I'm looking at what the EHRs are doing with engaging the vendors. One of the items we have on our to-do list – and, I believe our ONC lead sent us some information this morning – is to do a cross-reference of what's currently required for collection in the 2015 edition certification, so that is on our agenda to look at as well.

Steve Ready – Norton Healthcare – Member
Very good.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Christina, that's with the thought that if it's required, then the systems are allegedly capable of providing it. It's a question of turning that functionality on rather than building it. So, that's a thought.

Christina Caraballo – Audacious Inquiry – Co-Chair
Exactly. If we think back to the guidance Steve gave us at the beginning, it was what we can do now with the USCDI, and it's not our future, but our present, so we want to make sure that our recommendations align with what's currently available. To your point, Terry, that's the turn-on switch. Should we move our discussion to the clinical notes? I think we've still got some work to do around provenance, but we've got a little bit of homework.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think that was a very helpful discussion. Do we have any more committee members who have joined who are maintaining radio silence? I guess not. So, we'll go into clinical notes. So, this is an interesting area, and I dropped a couple of pages into the Google docs earlier this morning, which I'm sure none of you have seen, but what struck me most about this list, which is a perfectly good list – it's really a subset of the HL7 consolidated CDA document types, missing a few – but basically, when you think about clinicians – when I wear my clinician hat and I look at this, I will say that I need every one of these, and if I get them, it will make a significant positive benefit to my practice.

So, I think it's a great list from the perspective of clinicians, but… The "but" is where I think I'd like to take this discussion because this is the easy part. It just makes sense to hospitals and ambulatory care practices – the eligible providers under meaningful use. But, care is getting much more complex in the sense that the value-based payment models are forcing those of us who assume risk for the management of these complex patients to communicate with groups that were never part of meaningful use and therefore have very little in the way of IT support or technology at their disposal, and furthermore, have data needs that are quite different than the eligible providers.

So, it's at least a twofold whammy. We've got to get different data, and we've got to get it in a way that's probably not going to be based on the Epics and the Cerners of the world. It's not going to be a CCDA. It's probably going to be a FHIR-based app. So, I think it puts a different spin on this list. But, having said that, Sheryl and Steve, do you have any thoughts about any glaring omissions in this list?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
The only thing that I'm seeing – and again, maybe this would be included in one of these eight areas – is the coordination-of-care requirements. So, if someone's leaving the hospital and they need to go to a nursing home, where would that show up in all of this?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. That's a good question.

Clem McDonald – National Library of Medicine – Member
This is Clem. I think it's in another part. I believe there's something like that in the USCD 1 thing.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Clem, there's a transfer summary note type under CCDA. That's where we intended to have that part of that live.

Clem McDonald – National Library of Medicine – Member
So then, why don't we suggest that transfer summary? And, this wouldn't be a CDA, this would be a FHIR thing, but it's the same question.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. If I were to pick apart this list, I would say that as a clinician outside of hospital and ambulatory practice, the discharge summary is much less valuable to me than a transfer-of-care summary. There are a couple reasons.

Clem McDonald – National Library of Medicine – Member
They're so rich that you don't want to take it off. They usually have a much more thorough report than other reports.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Absolutely, but what it does for me as a downstream provider – I'm in a skilled nursing facility or a home-based provider – is that it includes information of no use to me, so A). It's cluttered, and B). The discharge summary doesn't contain any information that's really relevant to the care of the person in front of me. So, the discharge summary won't go away, but in my mind, it doesn't serve the purpose of the transfer summary.

Clem McDonald – National Library of Medicine – Member
I go a little bit – I've not been seeing patients for about 10 years, but it was the most precious thing. Maybe they've gotten crappy now, so it might have gotten distorted, as a lot of them have, but when

they're written well, they're a really good thing because it's human-written, it's human-organized, and it's got all the key results – at least, it used to.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And, I'm sure there are still some exactly like that which are two pages long and right to the heart of the matter, clear, and concise, and then there's a 40-page one, which we're seeing more and more of because all you need to do is push the button, and the EHR automatically grabs big sections of whatever.

Clem McDonald – National Library of Medicine – Member
Ouch. Okay.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And so, you end up with these *War and Peace* discharge summaries that no one is ever going to read, and it doesn't matter if it's got every piece of information you need in it, you're never going to find it because by the time you get to page 10, you're tired, and you're not going to go any farther.

Clem McDonald – National Library of Medicine – Member
Did you write part of that article in *Fortune* magazine?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I didn't read it.

Clem McDonald – National Library of Medicine – Member
It ripped up electronic records, just fierce –

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Oh, I did read it, yes. And, absolutely. Ouch. So, you need the discharge summary from a regulatory standpoint. Hospitals are always going to need the discharge summary to justify the care they provided, but I think as an important addition to this list, I would include the transfer summary, which, in my mind, is a very specific dataset to provide what the receiving clinician needs to continue safe, appropriate, effective care, and that's very different than a discharge summary. It really is a problem-based, condition-based review of the care targeting individual conditions, with a concise, bulleted report on each one.

Steve Ready – Norton Healthcare – Member
In your mind, would that statement apply to all social service referrals?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Social service referrals… The farther you get out from the center of clinical medicine – the eligible providers – the information that you need as a provider changes and becomes less clinical in the sense that it's stuff we deal with all the time in the hospital. It becomes much more…I don't know what the right word is. It becomes a bit broader in that it includes issues of function, cognition, social

determinants, levels of support – things that rarely have made it into the discharge summary, in my experience. Steven, did your question refer to, say, a referral to home- and community-based services?

Steve Ready – Norton Healthcare – Member
It did. That's where I was going.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. So, they're non-medical. They don't really care about the diagnosis list. They might on the medication list, but maybe not. Where they would care about it is function and cognition, and how much support a person has at home, and whether they have food security, and whether they have transportation to the next site of care, and how their housing is. So, it's all that stuff.

Leslie Lenert – Medical University of South Carolina – Member
This is Les Lenert. What I've written about in this area is to use SBAR for the kind of summary you're talking about – situation-background-assessment-recommendation – the handoff language specifically for this kind of transfer document.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. Should we add "transfer document-SBAR" to indicate that it really is an abbreviated document?

Leslie Lenert – Medical University of South Carolina – Member
I think it would be great if you cross-referenced it because then, people would know exactly what you meant by this transfer document, that it's really a digital handoff.

Christina Caraballo – Audacious Inquiry – Co-Chair
Sheryl, you have your hand up. Are you waiting to put in a comment?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I agree with what was just said, and also, I had one other question. So, where would medication adherence, medication reconciliation, or what medications have been prescribed – are those in the consultation notes? Where would we find those?

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

Clem McDonald – National Library of Medicine – Member
This is – never mind, go ahead.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Go ahead, Clem.

Clem McDonald – National Library of Medicine – Member
That's a very difficult challenge in general, and with the ability to get medications from a lot of places, which FHIR will allow, it could totally change the game. I don't know if we should lock it down as a

separate, handwritten thing when there will be the ability to find out which medication's been prescribed – you just ask the patient about all of them. That's not really feasible now. You ask the patient what they're on, and they'll tell you, but it may not be right. You don't know what the **[inaudible] [00:38:15]**.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Right. So, one thing we've been talking about in the Da Vinci Project is the ability to respond with an electronic message that indicates either the patient has not picked up the medication or that they have, and where does that go? Is that memorialized as part of a clinical note, or is that some other piece of data that we need to define a data element for? The challenge, quite honestly, has been that with the work that we've done, we want to provide that data, and many of the EHR systems are not picking it up.

Clem McDonald – National Library of Medicine – Member
Well, there's more than one way to skin a cat because there's now a message from NCPDP where you can send to a pharmacy and find all the drugs that are there, which is probably more important than one-offs each visit where you're getting hit by one more message. So, I just think it needs a little evolution.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Med reconciliation is a complex process. A reconciled medication list should be pretty simple, but connecting the process to the list is where everybody runs into the wall because it's not well done, and it's difficult, and it's very time-consuming. It's extraordinarily valuable, but in Canada, the reconciled medication list is flagged as the best medication list currently available, which is a recognition that it's as good as you can do. The gold standard is that the homecare nurse goes in and takes every medication he or she can find under the cabinet or on the kitchen table, puts it all in one big pile, and then goes through it with the patient, saying, "Are you taking this or not?" That's as close as we get to a real medication list.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, there is a data class for medication in the USCDI Version 1 and the data elements of medication and medication allergies. How does that tie into this discussion on clinical notes? Is it separate?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Sheryl raised the question about whether we should have a medication note. I would agree with that idea for a couple of reasons. I think it's critically important and deserves to be flagged all by itself, but also, there are parts of the healthcare system that need to know the medications but don't need to know anything else in the transfer summary or the discharge summary. They don't need any other clinical information. In a sense, it's a way of parsing out information, getting it to those who need it, and avoiding sending information that they don't need. So, I would second Sheryl's nomination of a reconciled medication list as a separate and distinct note.

Clem McDonald – National Library of Medicine – Member
Isn't that going to be more work for the office that's already dying?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Maybe "note" is not the right word. Maybe it's a template. It could fit within a source of any other notes, but it ought to be separate and distinct so it can be parsed out. I think that's my only –

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Right. The point is that we're not saying this is, again, required. We're saying that this is recommended, and the hope is – because I know Anthem and others – it's not just us, it's others that are involved in the FHIR work – are all trying to move this to an automated solution. So, if we were able to work with the EHRs, which we are doing, for this medication reconciliation, then wouldn't it be nice, if they have they data, to be able to provide that as part of the notes? And so, if you can then have it done electronically, then I think that's going to add significant value. We're not saying that as a result of this list, we're adding burden to the physician. We actually want to provide the data because I think it's really provided outside of the physician where that data gets populated, and then, the physician has it available to them.

Ken Kawamoto – University of Utah Health – Member
This is Ken. Sorry to join late. Is this medication reconciliation something – I've just never seen it. Is the idea here that after reconciliation, some sort of note gets created to say, "As a result of today's reconciliation, this is the cleaned-up list"? Is that the idea?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Something of that nature, yes. Different people have different ideas of it, but the idea that the physician would then know that if they prescribed a drug, then yes, the patient picked it up. And, if a nurse practitioner goes to the home and looks at all the medication and says, "Yes, the patient is taking these medications," it's something of that nature so that you know the patient is actually adhering to the medication protocol.

Ken Kawamoto – University of Utah Health – Member
Wouldn't that naturally show up in things like a progress note or a consultation note as a result of reconciliation? I'm looking at other things on the list, and they all look like things that we tend to see a ton of in the system versus this one – I don't know. I'm a little bit hesitant about things that may not exist even in 0.1% of health systems right now…I don't know. Because of the way we do reconciliations and how those results are transmitted, it's unclear what that will look like. Anyway, I'm not sure about this one.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Ken, that's a good point. I mentioned before that reconciliation is a process, and a reconciled medication list is the result of that process, and our biggest challenge is connecting the two because it's not consistently done either within or between systems. But, having said that, I think there's value in the latest, best understood medication list a patient is on, recognizing that it changes tomorrow.

Ken Kawamoto – University of Utah Health – Member
Yeah. Just thinking through it, the same thing is probably going to be true of things like the problem list and allergy list, so I think the question is – maybe thinking less from a document-centric perspective,

how do we envision that happening with the latest care plan? Are we thinking that each time there's reconciliation of those kind of things, a new note will be dropped that will be pulled, or is it more that there's some metadata that's kept that says, "Hey, this is the result of the reconciliation"? I'm just trying to imagine what the end outcome is going to be as we try to think of the best way to do reconciliations.

Clem McDonald – National Library of Medicine – Member
Could I chime in? I have my hand up. I don't usually do that, so I wanted to take credit. Well, I think the key problem with reconciliation is not knowing the universal list, and we did a project here with Surescripts where we got the universal list to the ER, and they just loved it because it was really easy to check off, and they found stuff that was not on the list from Surescripts as well as stuff that was. The point is that if you get that master list, which I think the insurance companies can deliver, you've got a whole new game. So, I think they should first get that list, and then it could be the grist for checking off with the patient.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
For establishing a new reconciled medication list?

Clem McDonald – National Library of Medicine – Member
Yeah. And, whether it's a new list – you just signal the list of medicines that there's something about it. You don't necessarily need another list. You could say, "These are all the medicines you've ever been on, these are the ones that are prescribed," and you could highlight – turn off and on what's reconciled or not because nothing's ever final and for sure. They hardly ever are with narcotics, for example.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Ken, does that process that Clem outlined make sense? Would that address your concerns?

Ken Kawamoto – University of Utah Health – Member
I think so.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
To the broader point that you raised, Ken, what about reconciling allergies or problem lists? If your system does both of those, kudos, because I think they're the only ones doing it, and that's another huge frontier, but it's not on our list of things to do, though it is of huge value for future work. But, I think we need a reconciliation process for both of those that's as explicit as it is for meds.

Clem McDonald – National Library of Medicine – Member
But, it's worse with those because you have to go to 20 different doctors. The patient doesn't know. You always get 42 different dermatology drugs on the list.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I wish it were easier. But, maybe we should think about how we lay the foundation for that process to occur in the future. We don't have to create the process, but…maybe MedRec is the model. Anyway,

that's out of scope, but really critical. So, we were going through this list, which is really the – Clem, I thought this would really make you happy. This is the meat and potatoes of clinical medicine.

Clem McDonald – National Library of Medicine – Member
Oh, I love it, but I do have one worry. They have this thing called a laboratory note, and if you read the whole stuff, it says, "This is for impressions and the narrative time." I'm afraid it'll give an excuse to labs to start sending what they now send as structured stuff as glop, so I think we ought to highlight that this is meant for narrative summary sort of text things that a lab might send, not like a Chem 12 to glom them all together.

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

Clem McDonald – National Library of Medicine – Member
I think that's the intention.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, I was thinking besides the transfer note and medication note, missing from this list of clinically valuable note types would be an advance care plan note or template.

Clem McDonald – National Library of Medicine – Member
I agree, but that gets complicated because different states have different… They're not necessarily notes. There are structured versions of them too.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I'm not saying – I wish it were simple, but I think in terms of valuable notes, if I were to receive the statement of the individual's goals and preferences at end-of-life care, I don't care what the format is, so I would love that note.

Clem McDonald – National Library of Medicine – Member
But, you've got to have signatures and stuff. I agree, I just don't think we can design it on a phone call.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
No, no, no. I'm thinking there's a different – so, that's where provenance would come in. "How did you come to this note, anyway?" I just want to see the note, and hopefully, we'll figure out how to go back and unwind the note to know if its sources were valid or true if we needed to. The quickest way to validate is to ask the individual, "Are these still your thoughts, beliefs, and desires?" But, I would add the advance care plan, and Lisa Nelson pioneered the HL7 patient-generated note type, of which this is a subtype, and it's the first template for patient-generated data through CCDA. It's a critical piece for not only what is contained in the note, but the fact that there's a process embedded in that note to memorialize patient-generated data. So, I would vote to add advance care plan notes. I would nominate them.

Ken Kawamoto – University of Utah Health – Member

This is Ken. I second that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. All in favor, say aye.

Clem McDonald – National Library of Medicine – Member
Well, I disagree because I think there's – we're doing it from a very high level, and we're going to make somebody write some more stuff that's going to add more of the text you see in various things. It hasn't been worked out in detail. There's a lot of activity underway to actually get the standard form with the signature made available, and there's advance directive, there's three or four different kinds – you all know that, of course, because you're living it. I think we should push the deeper process instead of making another handwritten note or hand-typed note.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
When I say "note," "template" may be a better word. It's just a document that has content in it.

Clem McDonald – National Library of Medicine – Member
There's work underway – and, I don't know for how long it is, but I think we should explore the work that's underway before we force another note or template. The templates are all different, too. That's the problem.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And again, similar to MedRec, this sort of information has huge value outside of the immediate eligible provider community. It's valuable across the entire continuum of care, and for that reason, in an attempt to make this a broader community of service providers able to exchange interoperable information they're able to generate and see is the next step of where interoperability needs to go, which is to build these caretaking communities. That's another reason why I like advance care plans. But, your concerns and objections are noted, Clem, and you're right. It's not easy, but that's okay. We don't have to do it, we just have to recommend it.

Clem McDonald – National Library of Medicine – Member
I recommend the idea as good, but I think it's got to be formulated crisply in terms of reality and stuff like – people don't trust the notes if they don't have the document. There's a lot of complexity. As far as I know, they're not going to pull life support because of somebody's handwritten note unless they know them. It's complicated.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right, particularly because there have been successful lawsuits for patients with advance directives that were not followed who successfully sued clinicians for assault, and for inappropriate advance directives which were not certified where the person ended up not being resuscitated and the family sued because of that. So, it is a knife edge, I agree. Okay, I have a list of other things. Maybe the biggest one – how are we doing on time? We have another half hour? Okay.

It has to do with quality reporting, quality metrics, and query/response types of document. As interoperability gets better, to my mind, the holy grail of quality measures is going to be to take the clinical data that we all generate as part of taking good care of our patients – that that really populates the quality metrics. And so, it's to think if there's a standard template that we might come up with, where we're looking at aspects of good care, recognizing their presence or absence based on what's in the electronic record, and then using the electronic record to generate the report in the background.

So, for example, if I told you that a transfer note had to arrive at the receiver before the patient did – so, it's got a timestamp – and that it contained the following five items, we could do a measure that says that the five items were there and it got there before or didn't, and it would give you a quality score on thousands of transfers, and it wouldn't be something you had to do other than making every transfer summary and getting it out in a timely fashion. It would measure that. So, that's the thought behind that.

The other thing about quality measures is they're heavily focused on the eligible provider community, and then, off through CMS-regulated areas – SNiF, home health agencies, LTAC. But, they peter out pretty quickly once you get beyond that, particularly in the home- and community-based services province, and yet, those folks are as much a part of an episode of care as anybody else. All right, I'll stop there. What does everyone think about quality metrics? A bridge too far? Or, are we all in favor –

Clem McDonald – National Library of Medicine – Member
I'll pass it to Ken.

Ken Kawamoto – University of Utah Health – Member
Well, in the USCDI, putting in quality metrics – I didn't realize it when I was reading through the NPRM. What are they specifically recommending?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, they're recommending this list. Is there anything else we want to add to it?

Clem McDonald – National Library of Medicine – Member
Not for quality metrics, I don't think. I think they're following the same path, but trying to make it simpler. That's my quick recollection.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
No question there, but they also want to know if we thought there are other note types that we should look at.

Clem McDonald – National Library of Medicine – Member
Well, the quality stuff is managed in a different pathway though, right? Does all this meaningful use stuff and the statistics – there's a very elaborate system with languages and stuff to compute it. That's why I passed it to Ken.

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

And, my counterpoint to that, Clem – you're absolutely right, and I agree it's a separate track, but again, in the evolution of quality metrics, they're really moving as much as possible toward clinically generated data rather than having someone come back, look at your entire dataset, and pull out the numbers.

Clem McDonald – National Library of Medicine – Member
Yeah, and I like that, but I don't think it's a note.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I don't know what it is. You're right, it may not be a note. It may be a template. Well, let's table that one. There doesn't seem to be overwhelming support. So, let me go on to two more things. Again, in the spirit of providing information that's needed by providers who are not the original eligible providers, there are really two clinical areas of huge value, and one is functional capability, and the other is cognition.

Really, a separate description of each of those would be extraordinarily valuable, certainly to me as a geriatrician and someone who takes care of people at home and in facilities, because it turns out that those two measures – function and cognition – function is a better prediction of readmission than anything else, better than your diagnosis, and function and cognition together make up much of the concept of frailty, which turns out to be the best predictor of survival, institutionalization, and long-term service use – aggregate service use. So, those two concepts of cognition and function have tremendous value in many domains. I wonder if that's sufficient to give them their own note type.

Clem McDonald – National Library of Medicine – Member
Isn't there a variable you want to specify? How are you actually collecting it? That would be wonderful, and I think there's a way to propose – like head circumference in kids – some specific measure that's some kind of a validated instrument. What would you propose?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, there are certainly a whole bunch of them.

Clem McDonald – National Library of Medicine – Member
Yeah, but it doesn't help the world adopt one when you say, "Go find them."

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, what we could do as a start is to take the IMPACT Act work on the federally mandated assessment instruments, particularly MDS for SNiF, OASIS for homecare, and IRF-PAI for IRFs and LTACs. So, the IMPACT Act said that CMS needs to create an interoperable set of functional and cognitive descriptors used across post-acute care, and they will be housed in the data element library. So, starting there would be a great step.

Clem McDonald – National Library of Medicine – Member

But, can you pull out the two, five, or 10 – whatever it is – questions? I think there should be a caveat. You don't have to do head circumference when they're not kids, and you shouldn't have to do a cognitive thing on a 12-year-old who's not performing – some qualification about age or something.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, that makes sense, by all means. But, it's really for people who've – again, it's when there's impairment that's neither function nor cognition that we're more concerned. But anyway, I would nominate those two as a separate dataset that has unique and persistent value across the continuum of care, just like medication lists and advance directives. And, the whole point is trying to lay the foundation for this much broader web of interoperability that rests on the original list of note types up above. Certainly, that's at the center of it, but in my mind, that can't be the end of it. So, let me nominate those two and see what folks say.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. I just have a question for clarity and perspective. So, the two that you're nominating are the ones on the bottom, reconciled medication note and advance care plan, which were the two topics I brought up. Again, what I was hoping – just to clarify for the medication note – was to be able to have a repository, if you will, or someplace where medication reconciliation that hopefully will come in an automated fashion so that it will be able to be passed on when needed for care coordination and other kinds of things. I vote for including the two that are there, and I did offer to provide some verbiage, if needed, for that. And then, I have a question for the advance care plan that's on this list, because I thought what we had already learned – and, if I misunderstand this, please correct me – was that the CCDA would be replaced by the USCDI. So, should we be using that in our grid, or should we be using USCDI-based patient-generated notes?

Christina Caraballo – Audacious Inquiry – Co-Chair
So, the USCDI is replacing the Common Clinical Data Set. My understanding is that the use of the CCDA, FHIR, and other standards will still exist. Is that correct?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The Common Clinical Data Set was really just dropped in, and that's sort of version one of USCDI. So, it didn't disappear, they just renamed it.

Ken Kawamoto – University of Utah Health – Member
The USCDI and Common Clinical Data Set were not ever going to replace anything from HL7. They're complementary to the HL7 standards.

Clem McDonald – National Library of Medicine – Member
Just to clarify, which HL7 standard are we talking about? The push is for FHIR.

Ken Kawamoto – University of Utah Health – Member
It's FHIR for the new proposed rule. And, the Common Clinical Data Set was used mostly with CCDA, so USCDI is very much aligned with ARCH and with FHIR. ARCH is like a profile on the entire FHIR standard, and then, USCDI are the data classes and data elements that constrain ARCH.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. So, just for my clarification, then, the use of CCDA relating to advance care planning is appropriate, then. I didn't know for sure. I was just asking. As one that's still struggling to make all the pieces fit in this puzzle, I didn't know for sure.

Clem McDonald – National Library of Medicine – Member
Well, I'll go back to my other theme. I think this is something that needs a working group to work out all the details, and it might take another year, and doing this stuff just to say "Do it" is damaging. It won't help. Something funny will come out, and maybe it interferes with the standards process.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Clem, I agree with you. We don't want to push something that's not ready for prime time anywhere, but thinking of this list as a telegraph of what we're thinking is coming without any –

Clem McDonald – National Library of Medicine – Member
Well, what about if we said that we should encourage the current efforts to get done with a mechanism for reporting the various things? It's a living will. It's not just – there are three of them, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, multiple –

Clem McDonald – National Library of Medicine – Member
We should push them to get it done rather than telling them what it is.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. So, I'm just thinking we need – I don't want to tell them what it is, I just want a place to put it when we figure it out.

Clem McDonald – National Library of Medicine – Member
But, it might not be a note. Maybe it's just a bunch of observations and some attached scanned documents that have the patient's signature or electronic signature on them.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
You're right, it's a complex piece. But, just thinking in terms of information that would be contained in such a note, template, document, or whatever we call it, that's the level that I'm thinking at, and it's not too much more granular than that. This is really high-level stuff. This is not an attempt to define what's in it. Your concerns about pushing ahead before things are noted are well taken. All right, in the spirit – now that I've worn you all down – in the spirit of thinking inclusively across the continuum of care, there is one more nomination that I'd like to make, and that's really the long-term services and supports and the home- and community-based services care plan note.

Steven mentioned that end of this continuum earlier. It's really a way for these very non-medical home-based service providers to communicate their observations and share a care plan with the rest

of the care continuum. Currently, this doesn't exist, but it's about to go to ballot in HL7 from work that was done on the S&I framework called ELTSS, and I think there's a link to that in there somewhere. If not, I'll get a link. So, my final nomination is whether we want to think about a note that enables the non-clinical end of the healthcare continuum to communicate in standard vocabulary and format with the rest of the healthcare system around the issues that are really important to both ends of the continuum. Or, is everybody tired, and do we want to call it a day and take public comment?

Ken Kawamoto – University of Utah Health – Member
Don't we need to take public comments anyway?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I vote for that.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
We'll all vote for public comment. Okay, fair enough. Yes, we have to take public comment.

Lauren Richie – ONC – Designated Federal Officer
We'll take a quick mental break and let that sink in a little bit. We'll pull up the phone number here in just a second. And then, operator, would you please open the public line?

Operator
If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 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 *.

Lauren Richie – ONC – Designated Federal Officer
And, I just want to confirm – I know we were joined later by Les, Ken, and Clem. Did anyone else join that didn't announce themselves at the top of the call? I just wanted to double-check. Operator, do we have anyone dialing into the queue at this time?

Operator
Not at this time.

Lauren Richie – ONC – Designated Federal Officer
All right. So, I'll hand it back to you, Terry, for the last 11 minutes or so.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Well, diving into the details, how about if we step back a little bit and get a sense from the committee… It's hard to articulate this, but let's get a sense of the level of detail at which our recommendations should emerge. Now, are there 50,000-foot, 10,000-foot, 1,000 – clearly, we can be lower than that, but I just want to get a sense of if we should be ultra-high or moderately more directive. I think that's the challenge we have as a committee. At what level can we pitch these ideas

that don't make people run away and hide, but on the other hand, we don't foreclose some valuable connections that are going to be important for us later on? Let me pose that to the group.

Christina Caraballo – Audacious Inquiry – Co-Chair
I think Clem brings up a really good point. I'm sitting here thinking through things and don't have the answer yet. Where does this live? For example, if we're looking at advance care plans, I know that that's been in certification, I know that there are standards that are really well developed that support incorporating advance care plans, and I think it's extremely important, especially for patients to be engaged in the care continuum, but I don't know where gathering that information lives. Is it a clinical note? Is it in a different area within the USCDI? I'm just not sure, so I'm struggling there with our discussion. I'll pause there and get people's thoughts.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. As a payer, I can't say that I'm the best one to say where this belongs. I imagined it was a clinical note, which is why I brought it up, but I don't know. I think we need the folks that are actually on the physician side to best say where this should be grouped. I just know that it would be valuable, and it's something that, as a payer, we're constantly trying to understand and follow up on to ensure that all of the care coordination activities have been performed and that we know who has performed them.

Christina Caraballo – Audacious Inquiry – Co-Chair
I really agree with that. Where would the value in this be? Where does it live?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Sheryl, as a placeholder, should we propose a care plan note, not knowing what we have to put into it yet or not knowing everything that should go into it?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
It sounds like that would be the way to go, but maybe others can weigh on that. When we discussed it, it sounded like it would be a very important aspect, and it's something that any transfer facility would want to have relating to what the expectation is in terms of ensuring the safety and, hopefully, the improvement of the patient.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Thank you for that. Any other thoughts or comments from folks? We are six minutes from the end. So, if not, I'm going to ask Ken a question, since he's the…ISPTF representative. Are there things on this list or not on this list that have come up with…ISPs that we should think about?

Ken Kawamoto – University of Utah Health – Member
I think it's going to come through more when we do evidence-based disease management, but I think it'll be very under specific conditions.

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

Okay. One of the things – when you talk about a transfer of care summary or a care plan, they end up – they all have sort of a standard format, but they're infinitely variable because the list of conditions is different, and each condition has a different set of required information, but I always think of this stuff as really being modular. If we were to identify a list of common conditions – hypertension, diabetes, COPD, functional impairment – we could create a description of that condition, a description of the central data elements needed to understand it, and a detailed plan about what is next considered for that condition. If we were putting a transfer summary together, we would take the 10 templates of conditions that apply to this particular patient and essentially stack them up, and those modules are then reusable as separate modules, a block, or however you want to do it. So, when I think about the disease-specific management, I see that as a vehicle to getting to condition-specific clinical modules.

Clem McDonald – National Library of Medicine – Member
I just looked up what's in the current NPRM, and before we get ahead of ourselves, the care plan resource must be supported currently. That is actually a data structure that has all the stuff you'd want for care plan, so I think we have to be doubly careful that we don't ask them to double up on stuff they already have.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, then, let's add it to this list.

Clem McDonald – National Library of Medicine – Member
No, it's already in the stack. It's going to be a resource, not a note. Care plans are one of the 15 resources that must be supported per the NPRN.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, that's part of the ARCH.

Clem McDonald – National Library of Medicine – Member
I don't know if it's part of ARCH. It's part of the notice of proposed rulemaking, and it's part of FHIR. You can search for "careplan" without a space on FHIR, and you'll find the specification for it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Clearly, it's a high-value piece of real estate, and I guess we can struggle with how best to align what we're doing –

Clem McDonald – National Library of Medicine – Member
Well, I think we have to be careful not to reinvent something that's been done.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I hear you. I'm with you.

Clem McDonald – National Library of Medicine – Member
It's done and it's in the requirements already. Now, maybe you want to have it changed, but then you go through FHIR to get it in the rules.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, but that's a different process. So, it's good to know that it's already in there. I had overlooked that piece. I have no argument with it being included one way or another.

Clem McDonald – National Library of Medicine – Member
There's also "medication," "medication order," and "medication statement," which are required. There's one other one that's not yet required that – what we might want to argue for is for there to be additional flags in it to see whether that thing has been verified, by whom, and when it was reconciled, and I would hope that the thing being developed by insurance companies would load that up with details from when it was dispensed, not dispensed, or whatever, but again, that's going to require committee work to get it perfect.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
That's helpful, Clem. Again, we're not trying to repeat anything or do stuff that's already been done. It's really more – so, what we'd probably need to do is figure out what of what we've come up with already exists, and we can just point to that. We believe this is a high-priority item –

Clem McDonald – National Library of Medicine – Member
I don't know why we've got to do a "pizza pizza" and say it again. Is it just to get credit? There's enough working going on. They're going to have to get this passed through a comment period and all that kind of stuff. I don't think we should pile on.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Nope, let's just make sure we've got all we need, and as long as somebody's got it somewhere, that's good enough.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Right, but I just wanted to clarify because I thought the way it worked was that even though NPRM required a care plan source, unless we added something into the USCDI, it's not a required data element that has to be shared. So, to me, it's two separate components that need to be handled, and I know that with this list that we were talking about right now, I think what we're saying is the source of that data would be already required under NPRM, but whether or not it's a data-to-be-shared element under USCDI would still be a separate activity or separate entity. That's the way I was reading this, and maybe that's where we should start for the next meeting, because we're already over time.

Clem McDonald – National Library of Medicine – Member
You should get a ruling on that because the whole purpose under the 2st Century Cures Act is that all this data is shared, at least, to the patient, and after that, they have some control over it. It says all electronic data must be shared – the Cures Act – and so does the NPRM, although maybe not as strongly. But, let's clarify because that's an important point. I'd like to hear from ONC what they really mean before we dig too hard. You're exactly right, it might be. I don't know.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

So, would it be possible to get someone from ONC to come and provide some background or clarity on that question for next time?

Lauren Richie – ONC – Designated Federal Officer
Adam or Stacy, can you speak to that?

Adam Wong – ONC – Back Up/ Support
Yeah, we can invite folks as needed to answer any questions that we don't manage to clear up during the call or during our proper debrief calls.

Johnny Bender – ONC – SME
If it wasn't the end of the call, I think I could probably speak to that, but we can have folks here for the next call to respond to that question.

Clem McDonald – National Library of Medicine – Member
That would be very helpful.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Let's pick it up there. Thanks, everybody. This was a great discussion, and we moved the ball today. Thank you all.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thank you, everyone.

Lauren Richie – ONC – Designated Federal Officer
Thank you, everyone. Bye.