U.S. Core Data for
Interoperability Task Force

Transcript
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Virtual Meeting

Speakers

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

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Hello, everyone. Welcome to the USCDI task force. With us today, we have our co-chairs Christina Caraballo and Terry O'Malley. The other members that have joined are Steven Lane and Sheryl Turney. Have any other task force members joined the call?

Christina Caraballo – Audacious Inquiry – Co-Chair
Hi, Lauren. This is Christina. Sorry I'm a minute late.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Yeah, I've got you. Thanks, Christina. I'm actually going to turn it right back to you for opening remarks and to get us started.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, great. I guess we can just move on to the next slide. So, today, crew, we're at the final stretches of getting ready to put our recommendations together for our meeting with the full committee next week on Wednesday, so Terry and I and our awesome ONC leads have looked at everything that we've discussed over the course of the last month through this task force as well as combined input we got from the last HITAC committee meeting when we presented our draft recommendations, and we have consolidated a draft recommendation for next Wednesday's meeting that we hope everyone has had a chance to review, so with that, we just want to go through, and we can go to the next slide and review what we've got so far. Next slide?

We know our charge, so we can move to the next slide – and then, one more. So, jumping right into the core of our recommendations, we've put together a slide of general principles that this task force followed, as well as an explanation of how we've moved through each section of the data classes we were asked to review. So, here are a couple bullets that we put together of guiding principles. We should be promiscuous with recommendations for new elements, and then divide those recommendations into two groups. The two groups or buckets that we've identified are those that can be implemented using current CERT functionality and those that will require new functionality or programming. That second bucket is probably more of our "future" bucket, whereas the first one is what we can consider turning on now.

For a way to present the data classes that we have been tasked to evaluate, we've broken each down into four slides. The first slide is ONC's recommendations with our response to those specific recommendations. The second slide for each of these is going to be to put in our recommendations and then move to – we jumped ahead one more; can we go back a slide? – our justification and questions that we have for the HITAC. Thanks, now we can move ahead. So, starting with the first one, which is the patient demographics – so, we can move to the next slide – we've got on this first slide – go ahead.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Just for the folks on the phone, we're going to edit these slides live, so you probably ought to pull them up in Google Slides at this point. The goal is that by the end of today, we'll have a final deck that we can submit, so we're going to make this a working session and actually wordsmith and talk about any issues that are not clear or any issues with which task force members have questions or concerns. So, I think Johnny was going to pull up Google Slides.

Adam Wong – Office of the National Coordinator for Health Information Technology – Back Up/ Support
Johnny's having some online login issues, so I guess if I can share my screen…

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do you want to take notes?

Christina Caraballo – Audacious Inquiry – Co-Chair
Yeah, and whether it's Google or just the draft that's not PDF, if we could do live editing for everyone to see, I think that's fine. Thanks, Terry, for the introduction.

Adam Wong – Office of the National Coordinator for Health Information Technology – Back Up/ Support
I don't think the Google presentation matches up with the current presentation at this point, so I'll just edit on the PowerPoint deck.

Christina Caraballo – Audacious Inquiry – Co-Chair
Perfect. That sounds great.

Adam Wong – Office of the National Coordinator for Health Information Technology – Back Up/ Support
I can share my screen. Is that correct?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Yes, that's correct.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thanks, Adam. So, as Adam is bringing that up, we've got our first recommendations so everybody can see. They shouldn't be new to anyone, but under the first, we have the address and phone number, we have called out some standard formats that we think would be helpful in reference, and then, for "phone number," we put at the top that we think the mobile phone number should be primary and the landline secondary. So, I'm going to pause on each slide and give task force members a chance to react or interject with any comments. Steven Lane, I see you're –

Steven Lane – Sutter Health – Member

Do you want us to chime in? Okay, great.

Christina Caraballo – Audacious Inquiry – Co-Chair
Go for it.

Steven Lane – Sutter Health – Member
Yeah, it's much smaller than my earlier meeting today, where they were crazy about the hand-raising. Have we done the analysis of U.S. Postal Service and AHIMA to see whether one subsumes the other? I would anticipate – so, I didn't do the analysis myself – that AHIMA absorbs what's already in the U.S. Postal Service? Rather than throwing out a number of standards, we might be able to simplify this by trying to identify one we want to throw our weight behind.

Christina Caraballo – Audacious Inquiry – Co-Chair
I think that's an excellent point. We did not do that. I'm taking a note. I feel like you're probably right that AHIMA references the Postal Service, but let's verify that.

Steven Lane – Sutter Health – Member
And, I only heard HDI on this call – again, I haven't done my own independent research, but it might be nice to have a crosswalk of those three that we're naming if anybody has an hour to dig into that and see whether one includes important elements that the others don't, or if they're really all pretty much in agreement.

Christina Caraballo – Audacious Inquiry – Co-Chair
I think that's a great recommendation.

Adam Wong – Office of the National Coordinator for Health Information Technology – Back Up/ Support
Can people see the note that I'm just lightly adding in those little brackets in the box?

Christina Caraballo – Audacious Inquiry – Co-Chair
Yup.

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

Steven Lane – Sutter Health – Member
I'll just comment – I think I might have missed the meeting or don't remember the decision to say that mobile is primary and landline is secondary, but I really like that idea.

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

Steven Lane – Sutter Health – Member

The other thing about this that's relevant – and, I don't recall whether we talked about it – with adolescents, this is a really key point. We have to be clear that the phone number is the patient's number and not the parent's phone number. I know we've got a slide coming up on pediatric demographics, but I think we should call out that these are the patients' phone numbers. It's very difficult when you've got the parent's phone number entered as the patient's phone number, and the kid turns 12, 16, and 19, and things are really crazy.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Actually, go back one slide and add that. Just add "Use patient's mobile phone number."

Steven Lane – Sutter Health – Member
The patient's individual, personal number, not the parent's or guardian's.

Adam Wong – Office of the National Coordinator for Health Information Technology – Back Up/ Support
Got it.

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

Christina Caraballo – Audacious Inquiry – Co-Chair
No, I wanted to – we were jumping ahead to the pediatric section, and I wanted to see if we were capturing the use of – well, Steven's point – under the pediatric. We have pediatrics all consolidated into recommendations around pediatrics, so maybe we want to capture that here as well.

Steven Lane – Sutter Health – Member
Well, what we have here is appropriate. We've got contact information for other individuals. I think the trick is making sure that we have the patient one on Slide 8 really well specified as the patient's. Essentially, a newborn doesn't have a mobile number, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Not yet.

Steven Lane – Sutter Health – Member
Right, one hopes, even in Palo Alto. That's the point I'm making, is that there shouldn't be a mobile number until the patients themselves have mobile numbers, and it shouldn't be relying entirely on these contact numbers.

Christina Caraballo – Audacious Inquiry – Co-Chair
So, one thing I want to think about on that statement is we were looking at the idea of moving down the – for "patient matching use case," that mobile number is still the most reliable if I'm looking for that 10% last final match, and that mobile number associated with the child is still going to be the best match until –

Steven Lane – Sutter Health – Member
It can still be associated with the child, it's just not the child's number. I think we can accomplish both goals.

Christina Caraballo – Audacious Inquiry – Co-Chair
I just want to make sure we capture it really clearly in our write-up.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, Steven, you're saying that – say you have a 5-year-old that doesn't have a mobile number. Their slot for "phone number" would be blank, but under "parent/guardian" or whatever, there would be an associated phone number.

Steven Lane – Sutter Health – Member
Exactly, and that associated phone number could still be used for patient matching.

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

Christina Caraballo – Audacious Inquiry – Co-Chair
Perfect. That makes sense. Any other comments on these two slides of patient demographics?

Steven Lane – Sutter Health – Member
I'm a little worried by the way you put that language. "Child doesn't have a number. Use parent's or guardian's…" You can say "for matching or other uses," but don't call it the patient's. I just want to make sure we really make that clear.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
If we go back to Slide 1 – rather, the previous slide – we could say "includes no available phone number," "indicate no available number." So, it's just not blank, it's actually a "no" with a flavor to it.

Christina Caraballo – Audacious Inquiry – Co-Chair
When I think about it right now, my daughter's phone number is my mobile phone number, and if I'm looking at the primary place to contact her if I'm…yeah, I don't know.

Steven Lane – Sutter Health – Member
It shouldn't be. Your mobile number should not be listed as her mobile number. That's what I'm saying.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, her mobile number should be listed as "none," and then, in the "contacts" area, it would be your mobile number as "parent."

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, got it. I'm overthinking this. I'm with you.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. I think the whole essence was to add the mobile phone number as a way to identify a unique person, so having the patient's parent wouldn't help.

Christina Caraballo – Audacious Inquiry – Co-Chair
Exactly.

Steven Lane – Sutter Health – Member
No, it would, because the parent's mobile number is associated with the patient as a demographic, and the parent's mobile number could still be used for matching.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Yeah, but it wouldn't help in the case of twins where they both have similar first names and there's already confusion. To me, I thought we were going to focus on the fact that it would be the cell phone number of the person because it's really looking for how we can create a unique identifier.

Steven Lane – Sutter Health – Member
I think you're supporting what we're saying.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think that's right, Sheryl, and I think this does that. It just makes it clear that either there is a mobile phone number associated with this person, which is their number that you can contact them on, or there's another mobile phone number associated with their parents, which is also associated with them. I think it works.

Steven Lane – Sutter Health – Member
But, you're right. The twins, the multiple preadolescents who don't have phones yet – you're right, there may be one parent number associated with multiple individuals.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, great. I think we're ready to move on to our next slide.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
On this slide, I added "contact information for children's services case manager." I'm happy to omit that. It was just a random thought.

Steven Lane – Sutter Health – Member
Well, it's certainly not specific to children. Any patient could have a case manager, care manager, et cetera, so I don't think it belongs under pediatrics specifically.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Let's just take it out, then.

Steven Lane – Sutter Health – Member

It also gets into the whole area of care team membership, which isn't really a patient demographic per se, so I would take it out.

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

Christina Caraballo – Audacious Inquiry – Co-Chair
Great. So, I think we're ready to move to the next slide. This is a summary of the key discussion points that we took from our calls. We've identified two principal use cases for patient demographics, which are patient-matching and clinical care. The standard address including past address is a reasonable addition. Mobile phone number stood out as the most stable identifier. Future iterations of the USCDI should consider biometrics, but we had consensus that they're really not supported at the time for prime time. The pediatrics demographic set recognizes an immediate need of service providers to provide clinical care. And, secondary attributes of complements to matching logic in USCDI are valuable and will facilitate downstream matching and linking.

Steven Lane – Sutter Health – Member
Another use case that we haven't talked about is identity verification, which I think is important, and I don't know whether you guys feel comfortable adding it at this late date, but having lots of different demographics certainly allows you to assure that you've got the right person in front of you.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, that's a good point. So, maybe we need to say "three principal use cases."

Christina Caraballo – Audacious Inquiry – Co-Chair
And, Steven, I actually think that was discussed in one of our initial calls and somehow lost, so, thank you for bringing it back up.

Steven Lane – Sutter Health – Member
Well, I don't think I was there, so that makes it an even better idea.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
There was a cryptic note that said, "Do you know who I am?" I think that was our reference to individual identity.

Christina Caraballo – Audacious Inquiry – Co-Chair
I see no hands in the queue, so I think we're safe to move to the next grouping. We've got a couple questions for HITAC asking about more priority use cases besides the three that we just identified. Should we look at the balance between benefits and burden of the proposed changes, and is it reasonable to require CERT to turn on what's available?

Steven Lane – Sutter Health – Member
Is it right for us to leave No. 2 as a question, or should we make any suggestions there? Clearly, the benefits are the use cases, though there's clearly – with this pediatric mobile number, one of the

benefits, of course, is improved patient privacy. The burdens, of course, are on the organizations that will finally be called to standardize the way we collect this data, and then, we will be called upon to figure out how to share this data.

Christina Caraballo – Audacious Inquiry – Co-Chair
Steven, I think these are more like guiding questions. So, based on our dialogue and discussions – things that we've discussed and questions that came up to guide the group – so, based on our recommendations, are there any glaring benefits or major burdens that we didn't think about in these recommendations? It's kind of getting people to look back a slide.

Steven Lane – Sutter Health – Member
Maybe it's just the way the question is phrased. Are there additional benefits or burdens that need to be considered?

Christina Caraballo – Audacious Inquiry – Co-Chair
I like that.

Steven Lane – Sutter Health – Member
Although, I don't know – in the previous slides, we actually listed out… We don't know the benefits and burdens per se.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
An alternative would be to put this on the previous slide that just says, "In the opinion of the task force, the benefits outweigh the burdens," and then, if HITAC members object to that, they can pipe up. At least, our little group – Steven, Sheryl, and us – I think we agree to that. This is just a potential alternative.

Christina Caraballo – Audacious Inquiry – Co-Chair
I like that.

Steven Lane – Sutter Health – Member
It just seems like as it's phrased, it's a pretty big question. That's fine. I don't quite understand Bullet 3 there. Do you mean to say "making changes in the 2015 CERT requirements"?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
No. I think our point here was that of the 2015 CERT requirements – all of the EHRs have that functionality, but it may not be turned on in all of the EHRs. So, they're able to do it, but they may not be doing it because it's not activated.

Steven Lane – Sutter Health – Member
Okay. So, this is more of a requirement for the customers of those products to configure and have workflows in place.

Christina Caraballo – Audacious Inquiry – Co-Chair

Right. I was thinking through that as a turn-on, and if all the EHR vendors are supporting the capturing and sharing of certain information, then what is it, and should it just be turned on for everybody to use as part of the concordant dataset? The goal is more data, not less, and if all the EHRs support it, but the providers aren't being told to just turn it on, then maybe we put it in as core because it's there and available.

Steven Lane – Sutter Health – Member
I think it's part of USCDI Version 1. It does that automatically, doesn't it? "You must have this data, and you must share it. You have to turn it on."

Christina Caraballo – Audacious Inquiry – Co-Chair
Right, but there are some – from what I've heard, there's this bucket of data that's commonly available across many EHRs that's not part of USCDI or required. We have not done a full assessment of this, but it is something that has come up in our discussion. I see Val has a comment as well.

Valerie Grey – New York eHealth Collaborative – Member
Hi, Christina. Mine is a minor one that goes back a slide or two, so it's not related to this conversation, so when this is over, I'll chime in.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay, great.

Steven Lane – Sutter Health – Member
I'm just still not clear on what Bullet 3 means, but if you are…

Christina Caraballo – Audacious Inquiry – Co-Chair
Terry, is there any other way to clarify that one?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I'm thinking… So, do we know – do we have examples of anyone who is not using their full 2015 capabilities? Do we know that as a fact? I guess if we do, then we can be pretty confident with the statement that they've just got to turn them on and get with it. If we don't, then, to Steven's point, this may just be extraneous and they're going to have to do it anyway.

Christina Caraballo – Audacious Inquiry – Co-Chair
Okay. So, I'm wondering if this last bullet should go into Phase 2, when we're looking at the expansion process, a recommendation to do an evaluation on what's commonly available across certified EHRs that's not a part of USCDI right now.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I think that makes sense, Christina.

Christina Caraballo – Audacious Inquiry – Co-Chair
Steven, how does that sound?

Steven Lane – Sutter Health – Member
Fine.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, we can drop it into our new Google doc for Phase 2.

Christina Caraballo – Audacious Inquiry – Co-Chair
Great. Okay, I think we're ready to jump back to the slide you wanted to go to, Val.

Valerie Grey – New York eHealth Collaborative – Member
Yeah, I just have a quick question. So, I think that we're recommending that we use current address and prior addresses. That was my understanding, and so, I wondered if on Slide 8, where we say, "The proposed data element is addressed in our task recommendations," it looks like we just say they should be standardized. Do we need to add that it should be current and prior? Do you know what I mean? On Slide 10, we say, "Standard address, including past addresses, is a reasonable addition."

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Oh, see. So, we should make that explicit in an earlier slide.

Valerie Grey – New York eHealth Collaborative – Member
Yeah, because it seems like that is one of our recommendations, but it's not actually in the table as one on Slide 8.

Christina Caraballo – Audacious Inquiry – Co-Chair
Great catch.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, good idea. So, here, we should say "standardized format and content for current address and prior addresses," or something like that.

Valerie Grey – New York eHealth Collaborative – Member
Yes.

Christina Caraballo – Audacious Inquiry – Co-Chair
You can just put "capture" – yeah, perfect. Adam's got it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Something like that.

Christina Caraballo – Audacious Inquiry – Co-Chair
Are we ready to move to data provenance? Any other thoughts on patient demographics? Okay. Adam, I think we can move to provenance. Terry, do you want to take us through this?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Sure. So, the three ONC data elements are on the left – author, author timestamp, and organization – and our recommendation was to drop "author" and use "source."

Steven Lane – Sutter Health – Member
I just think we need to define the term, because "source" could be interpreted as the organization, or the HIT vendor, or… We need to define it. I think what we mean is the individual or entity that created or documented the data. I think we mean the nurse that took the blood pressure or the… And, as we say, we need to define it. For the lab, is it the lab tech, is it the machine, is it the medical director? I think we said it would be the medical director, but we need to define "source."

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. We get into it a little bit on the next slide, but just thinking about how provenance is likely to evolve, "source" is likely to be a pretty – a not particularly granular element to begin with, with the exception –

Steven Lane – Sutter Health – Member
But, even though we're not going to have all the granularity – I agree with you – we still ought to have some sort of definition so it's not just garbage in. I had a couple of conversations just this week – I was chatting with Dave Perlman about this very thing, and his thoughts from Epic aligned with ours – looking at the source and the last touch was a reasonable place to start, but we still need to… As we said, this idea of a matrix that goes by data type, what's the right source for that data we say on the next slide, we've got…I think that's still important.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. I'm sorry, I raised my hand, but I was hoping "source" was still going to be some ID level for an organization, and now, we've added "name" and "location." Then, within an organization, you can always interrogate the system itself because the conversation we had that I was part of talked about with all of the records being updated, what are you going to use? Who's the last one? What must they have updated? All that sort of stuff.

So, if you're looking for an audit trail, you can always get that from within an organization, but in terms of interoperability, this is information that's going out to whoever's receiving it. They want to make sure that this is a trusted source and that the response to their inquiries comes from whoever they expect it to be. So, if I'm a patient looking for information or an organization looking for information, I hope that I'll know who some of the partners are – I might know who all of them are if it's an emergency situation – but from an organization, I might not necessarily have a way to evaluate a person or a name, so I thought we were talking about "source" being defined – and, I do agree we need to define it – as more of an ID that would be somehow created through some technical standard to know that it's a trusted source.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
In a sense, provenance becomes the assurance that it's from a trusted source, so what elements in provenance do we need to make that possible? And, at the highest level, it's probably to identify it on

an enterprise level. "This data came from Partners Healthcare." If you go back to Partners and say, "Okay, where did it really come from within your vast organization?", the audit trail is internal to Partners, and they can tell you it came from the lab at Newton-Wellesley Hospital. So, I'm wondering if "source" couldn't just be a very high-level institutional to begin with, essentially. What's the first door I have to go through if I'm looking for the actual source of this information?

Steven Lane – Sutter Health – Member
I think that's a really reasonable way to approach this given that we don't have all of this granular definition or agreement, but essentially – because they call out "author" and "author organization." What we're saying is that we really need the organization. That's the place to start because we don't have enough specificity of what it means to be an author.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Speaking out of both sides of my mouth here, we say it's a high-level institutional source, but on the next page, we say, "But then again, if it's a note, we want the particular – we want the author." If it's a radiology report, we want the author.

Steven Lane – Sutter Health – Member
Right, we want the radiologist.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right…I think.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
You're getting the right – is this the author of the clinical note, or is this the source of the interoperability exchange? That's what we need to define here exactly.

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

Steven Lane – Sutter Health – Member
Well, that goes back to the point about the original author and the last touch – the original organization and the organization you actually got it from. So, for each of these, I think that's important. Frankly, you probably want the timestamp as well. So, for "author," "organization," and "timestamp," you want – "author" shouldn't apply to the last touch unless it's identical. That's sort of the first touch. Or really, the other thing – which Sheryl just pointed out – is it's also the last edit. There's also the issue of "editor," which is not included here at all, but if data was edited from the time it was first authored, I think that's really important.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
So, maybe the way to handle this would be to say that for health information exchange, we need the transaction to be able to be mapped to a source which is an enterprise and a timestamp, and for a clinical note, you want to know who the author is, the author's timestamp, and the author's

organization if that's what you're keying in on. But, I think those are two different sets of data elements.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The question is whether you only need to have the first set. For interoperability, are you a trusted source, do I know who you are, and will you vouch for who it came from within your organization? I don't really care who the actual author is unless I want to go to a deep dive. What I really want to know is that it's coming from you and you're vouching for it.

Steven Lane – Sutter Health – Member
I'm frustrated by the fact that Steve Posnack clearly slapped us down and said, "Don't extend this too far for this first version." So, I think author, editor, last touch – those are all really important for the future, but we've been instructed to focus on this, so this is really the original author and original organization.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Well, there's nothing that says that in the first version, we can't say that what really need is the source and timestamp, and then, for future versions – although they're not part of Version 1 – we do see that we would need author, timestamp, and organization related to the various clinical notes. There's nothing wrong with having that in our recommendations.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. So, on this slide, perhaps in the white space, we could put a definition for "source" that says, "For interoperability, the source is the…identified entity making the information available."

Steven Lane – Sutter Health – Member
Isn't that just the organization? How is that different?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Whatever it is. And, the organization could be an integrated delivery network or a freestanding lab.

Steven Lane – Sutter Health – Member
Actually, that's a really good point. If the patient was at Partners and they had a lab drawn that was done at Quest, the organization is probably – I don't know. Is the organization Partners or Quest?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, if it comes through Partners, then Partners is, and if you asked Partners, they'd say, "We got it from Quest."

Steven Lane – Sutter Health – Member
Right, but in that case, is Quest the author and Partners the organization?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Is it the query or the response? What is it that you're exchanging? If you're sending out a thing that you need to have a lab order done, then it would be coming from Partners. They would be the source, right? If it's a result coming back, then the source is going to be Quest.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right, and Quest could send the results to the patient directly or to Partners, who then sends it on through a portal. So, for a first level for interoperability, the identify of the source is really at the entity level, and it's not any more granular than that. If we know where it came from, then presumably, within that source, they can actually drill down to find out who the lab tech was that drew the blood.

Steven Lane – Sutter Health – Member
I think we have to state that presumption.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, maybe we –

Christina Caraballo – Audacious Inquiry – Co-Chair
Terry, we might want to jump to Slide 14 because we have our discussion of the recommendations, and maybe we want to add some context around that, and we might have some of this captured in the discussion slide.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
But, let's put a definition on this slide so we're happy relative to "source," but I think you're right, Christina. We should then go to the discussion and amplify it. So, Adam, I don't think we have to put the definition on each line, but just at the bottom. "'Source' equals 'entity-level identifier,'" something like that. Would that suffice? Sheryl? Steven?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Maybe "level" or "organization." That works for me.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do you want to put "organizational level" instead of "entity"?

Christina Caraballo – Audacious Inquiry – Co-Chair
Just going back – I was pulling up our original Google document, and our grid says we had "author" as a subset of "sources," but "sources" can even be inclusive of machines, data aggregators, and other things. It's more inclusive than not, and this is just from previous discussions that we have highlighted in our Google doc.

Steven Lane – Sutter Health – Member
One thing I think we can do on this slide that suggests – so, it's "author," "author's timestamp," and "author's organization." I would change that to "author organization," the organization from which this data was obtained. I think that's what you're getting at, Terry, and the organization that would know the details – which nurse got the blood pressure, which lab tech drew the blood, et cetera.

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

So, maybe it's the originating organization – the organization that originated it rather than "author," which is tainted.

Steven Lane – Sutter Health – Member

Yeah, and I think this very common use case that you just identified – the Partners patient that has a lab drawn that is sent out to Quest as a reference lab. In my mind, the author is the medical director of the Quest lab, but the source organization is Partners, not Quest.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Right, but let's flip it the other way. If this is electronic, like a lab order, then the author would be the physician or physician's assistant ordering the test, and then the organization is Partners. So, in that case, wouldn't the lab need to know which doctor ordered the test?

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

You're right. That's a good point. So, that's the author of the order as opposed to the author of the result.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Yeah, the author is the one who's making the order. So, I do think there is merit in having all three here in that case because want to allow it to be supported by multiple types of use cases. We don't want to prescribe one type of use for it.

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

But, I would push back and say you're really talking about an internal process or internal workflow rather than interoperability. So…what information do I need from you as the originating source? And, as long as I'm happy that I know who you are, then I will take your information, and if I need more detail on where that information came from – who ordered it, which lab performed it – then I will ask you, but you don't have to tell me unless I ask you, which also is consistent with a last-point provenance. I only need to know where I got the information from. I don't need to know where you got it from. So, what if we changed "source" to…it's almost "originator."

Christina Caraballo – Audacious Inquiry – Co-Chair

"Origin"?

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

"Origin of the data." I'm trying to get the right word.

Steven Lane – Sutter Health – Member

And, are we agreeing that that's the actual person who harnessed the electrons to make the documentation?

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

Yeah, and then, whoever's moving that documentation to you. I just need to know who that is. So, within an originator, there will be multiple sources. There will be machines, there will be authors, there will be MRI units, or whatever, but we only need to know that the originator can find out. Again, "originator" may not be the right word. But, the general principle is that for interoperability, the entity providing the data that's being shared is considered the originating source.

Steven Lane – Sutter Health – Member
Really? So, you're saying that last touch would be the originating source?

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

Steven Lane – Sutter Health – Member
I don't think so. They use the word "author." That's the beginning originator, not the last touch. I think in future versions, we need to grab editors and last touch, but our task has really been to define the "author" piece.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah, but "author" is really too restrictive, unless you define it as "source." So, it's not the author. Again, it's not who necessarily created the data element, it's which entity is moving that data element.

Steven Lane – Sutter Health – Member
I think they've asked us to comment on "author," and I really do think it's the creator. I think the author is the creator of the source of the data, the timestamp is when that occurred, and the author organization is the organization within which that event occurred. And then, I think that in our commentary, we say that future versions of provenance should include editors along the way and last touch. But, if all they're asking us to comment on is "author," I think we should leave it as "author." I'll try to shut up.

Christina Caraballo – Audacious Inquiry – Co-Chair
But, not if we don't think "author" is correct. So, in other areas, we've said to omit certain data elements, especially in the pediatric section. I think this has been a core of our discussion. Do we have the right definition here, and is "author" the right word? We've discussed it extensively. I don't know the answer, but I don't think that leaving "author" and commenting based on this discussion would be the route to go.

Steven Lane – Sutter Health – Member
So, maybe it goes to the question to the committee – the question to the HITAC. Should "author organization" represent the organization within which the data was initially collected and documented, and/or should it include the last touch?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
My comment to "author" is I think it's too granular at this stage. To me, "author's organization," which is what we're calling the source organization makes more sense as a first stab at provenance.

Steven Lane – Sutter Health – Member

So, you're saying not to include author. But, as Sheryl keeps saying, if you're talking about a clinical note or an order, we know that data is available. We wouldn't want to exclude it. "Author" may be too granular for some data elements – the vital signs, which we've discussed – but for others, it seems like it's readily available, and we wouldn't want to throw it out.

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

Well, if we made the exception for clinical notes… If there's a discrete, identifiable author – "author" in the sense of whoever created this note –

Steven Lane – Sutter Health – Member

Then include it. But, future work would be to define how we're going to use the term "author" for other data types.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

I think at this stage, it's more important for orders. I can envision using this mechanism for orders and results, and I think it's more important that the lab, x-ray facility, or whoever it is knows that it's the doctor who's ordering it –

Steven Lane – Sutter Health – Member

But Sheryl, that's pretty well established. Ordering provider information is readily available for orders and results interfaces. I don't think there's a gap there that we need to close.

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

And, it's not really provenance.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

I don't know, so that's why I'm just throwing it out. If that gap is already closed, then my comment is not viable at that point. As I said, too, it's probably a lower priority, but I can see how it would have merit with clinical notes at some point.

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

Okay. Well… So, again, just to reiterate, I think at this stage of provenance, knowing the entity that is generating, packaging, and sending the interoperable information is the entity we need to know. I think we need to know it at that level as a first step.

Christina Caraballo – Audacious Inquiry – Co-Chair

So, can we leave "author" and add "source," or do we put "author/source" when "author" is not relevant as opposed to "source"?

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

Maybe our definition is just – again, it's the originator of the data, which is like we have – the entity-level identifier – except when there's an identifiable author, as in with clinical notes. Would that serve?

Again, I think the real discussion point is going to be around the last touch. That sort of underpins this. Okay. Well, let's carry on. We'll come back to this.

Christina Caraballo – Audacious Inquiry – Co-Chair
Sounds good.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Sounds good to me.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So then, we have our other recommendations, which sort of flesh out what we were just discussing, that we need more granularity about what sources are, and we get more granular later on. I think those are probably pretty non-controversial. The most controversial source item on this page is the first bullet under "Other," and that's proposing a standardized metadata template. Or, is that not controversial? Does silence mean assent or confusion?

Steven Lane – Sutter Health – Member
It means thought. No, I still think that makes sense – a standardized metadata template for each data type, right? Is that what we're getting at?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Type or element. So, each data element is going to get a tag, and it's going to say what kind of data it is – this is a test, this is an x-ray report – it's going to tell us who it came from – who the sending entity is, the source ID – and actually, it's probably not "source timestamp." It's probably the timestamp of when that data element was generated.

Steven Lane – Sutter Health – Member
How is that different?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, it's not when the source sent it, it's when…

Steven Lane – Sutter Health – Member
Oh, okay. Yeah.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The report was done on April 1st, but I'm sending it to you on the 5th.

Steven Lane – Sutter Health – Member
So, the 1st is the timestamp.

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

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Right. I didn't see this as being required for every data element. I saw it at a record level. So, what we're saying now sounds much more difficult to implement, and that's why I'm pausing. I didn't see it as the element level, but as the exchange level.

Steven Lane – Sutter Health – Member

Remember, the exchange is going to be much more than documents. It's going to go down to the FHIR resource level. So, we really need to think about the elements.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Right, but again, if we take this as the source of the data that's being sent, then what Partners is sending to the lab is all of the data that has been requested for this patient. So, at the end of the day, if you have it at the data element level, then just think about what that's going to mean in terms of the payload of what's going back and forth.

Steven Lane – Sutter Health – Member

But, I think that's what we want. We want it down at that data element level, so the data element metadata will include this.

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

And, the payload has got to be as light as possible. You're right, Sheryl. So, as a start from being able to know where the information came from, if we tag each element, then we'll know. We'll know we got it from Partners rather than from Steward Healthcare because the source ID is different even though the data type is the same.

Steven Lane – Sutter Health – Member

And, this gets at that issue of the patient's calm blood pressure versus the one collected in the healthcare system.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

My hesitancy is not knowing to what degree that can be implemented. What's going to be the burden to implement something like that, and is that reasonable?

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

Good point.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

I don't know. I'm just throwing it out there. For the most part, I envision that we're going to be requesting data and be the receiver. The burden is going to be on the facilities, the providers, and the labs providing data back and forth. It just seems to me like that's quite a large ask. I wouldn't want us to make a recommendation that essentially can't be implemented.

Steven Lane – Sutter Health – Member

I don't think the burden on this one is at the level of the provider or the data generator so much as at the level of the health IT system that's packaging up the data to send it. That kind of data is going to be in whatever this actual source system is. It's just the system in which the data was initially entered.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Right, but think about it: That's more like an audit trail than what we had discussed before, and that's going to end up costing providers more in order to have systems like this that can communicate it that way, because I don't believe that they do that today, and to me, that really speaks more of an audit trail than what we had said we wanted to go to in the beginning. So, again, I don't know the answers. I'm not as familiar with the technical workings of an EHR system. You guys are more the experts on that. I'm just throwing it out as the silent observer with many years in technology in many environments.

Steven Lane – Sutter Health – Member
I think your point is really well taken, but I must say, being involved in a lot of discussions over the last two days about how much providers can trust the external data that they receive and how important the provenance data is for them to have in order to integrate that external data into the workflows – whether it's a vital sign, a lab result, or a note – I don't think it's too much to ask, frankly, but I hear you. I'm not disregarding it.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Do we have anyone on this committee who represents the EHR systems who can speak to that? I can't. I'm just asking the question. I'm trying to see all sides.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, Ken and Steven are Epic shops. Again, my sense is that this is not a big lift. They're most likely tagging each data element already for their audit trail. In a sense, provenance is an audit trail.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
When it came up in our small group, we had agreed that audit trail would be in the future, and that's the only reason I brought it up again, but I'm fine with it staying in there. Again, I have no objection to it. I just want to make sure that it's something that can be delivered on.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yeah. Well, let's raise that in the discussion and the questions for the HITAC. I think you're absolutely right. We'll punt it to them. And then, the last tag on here is – and, if you remember way back about the original USCDI discussions about the reasons why data doesn't flow, one of them was local codes. So, this becomes a critical issue in interoperability. The data has to come out tagged using a standardized code set other than internal local codes.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I agree 100%.

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

Okay, next page. Ta-da! Moving along. So, this is why we chose "source," "entity," "originator," or something.

Steven Lane – Sutter Health – Member
I like "originator." I think "source" continues to include some confusion.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Yeah. I think I'm the original one that brought up "source," but it was because when I met with the FHIR group in my office, they talked about the fact that that's something they need already on FHIR transactions, so that's the only reason why I brought it up. I don't know if it means anything to have any consistency in the nomenclature, but that's the reason why I threw out that term.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, let me propose – let's say "originator/source." Let's mash both terms together.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
That works.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
We'll do that on the preceding slide as well. So, it's the originator/source. And, we would just repeat that wherever we have "source."

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Can I ask a question here? This might not be the right place, and I don't want to throw us off track because I think we're making good progress, but in the information blocking task force meeting we had this morning, one of the things we were talking about was consent. How do we know in the way we're going to exchange information when a patient has specifically declined to consent? The reason why this is important – especially in this regard – is sometimes they don't even want the provider that they went to see to be known by other providers. So, how would we envision that to work in this arrangement? Say a query went out. Is the originator going to say, "We're not allowed to share based on consent," or would the response be "Not applicable"? How would we envision that to work? Does that change any of the –

Steven Lane – Sutter Health – Member
I was also part of that conversation at the USCDI task force, and I think where we ended up with that was that roughly half the committee agreed that we should look to a future where consent data is part of USCDI with appropriate defined standards. The other half of the committee abstained.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I know. It was **[audio cuts out] [01:10:20]** conversation because I thought we brought it in because of Cynthia's comment, and then she abstained, so I didn't follow all that. But, to me, I'm looking at this and saying even in this version, how would it work if you had a patient that said, "No, I don't want you to share my data"? You certainly have data, but you can't share it, and they don't even want to share the fact that they saw you. So, how would that work if you get a query from someone? What is your

response supposed to be? In this version of USCDI, what would you say? "Not applicable," or "I don't have information to share" – what's the response we're going to get?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Well, it's out of our scope right now, but… It's probably a filter issue. So, before you release any information, you'd pass it through a final filter that had the individual's consent for whatever use. So, it'll be, "Sure, we have the information, we'll package it up, but before it leaves us, it has to go through a final checkpoint." And, at the checkpoint, the response might be "Not permitted use" or something like that.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Yeah, "Not permitted use." So, it wouldn't change anything that we're talking about here in terms of author or any of that. Okay, that's all I was looking at – whether that would impact any of those things that we're talking about. That use case wouldn't really apply, so I'm good.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Again, the other points on here – a unique and persistent identifier for each data element. Short and sweet – hopefully, these three elements are going to be enough. And then, we're going to need things. Christina and I are going to talk to Clem on Monday to see if there are any standardized taxonomies for data types and source types. If there are, we'll take them.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Yeah, I think that's a great idea.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And then, we start with these three things as our unique identifiers, and if we find that that's insufficient or excessive, then we'll correct it in the next version. We're not going to get it all right the first time around.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I agree. I think we're in a good place.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Moving right along… So, here's your data element question, Sheryl. Do we need it at this level? And then, the "last touch" question – these are big questions.

Steven Lane – Sutter Health – Member
Yeah, and I would add in the "editor" question. Again, it was really – I've been really focused on "originating source" and "last touch," but again, with some of the discussions we've had in ISPTF, anyone who actually modified the data along the way – who, when, what, and then last touch – it seems to me you eventually need the three. Yeah, the whole blockchain and the whole audit trail – you probably need those.

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

The way I've thought about that, which may be wrong, is if I know the source of my data – if I know it's coming from you, Steven, I only need to be able to go back, find you, and have you tell me where you got it from, and you may know who edited the original data – and, maybe the source before might be Ken, who sent it to you, and Ken may have changed data that he got from a previous source. But, I don't need to know that unless I ask, and in the sense –

Steven Lane – Sutter Health – Member
But, the way you're describing the ask is so labor-intensive as to be impossible.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Is it likely to be – how comment do you think it's going to be?

Steven Lane – Sutter Health – Member
Well, I guess I'm putting myself in the seat of these providers, who are saying to me, "Well, I'm only going to be able to integrate outside data into views, workflows, decision support, and analytics when I can really trust it." To really trust it, it seems to me you need the author, editor, and source – my source. It's like when you buy drugs on the street. Where'd it come from, who's messed with it, and who am I buying it from? Not that I do that, or even ever did that, but if I were to do that, that's what I would want.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
I would want blockchain…

Steven Lane – Sutter Health – Member
…on my weed.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right. So, that gets to Bullet 2. If you want to know the original source as well as anyone who modified it, then the payload around data elements might get really big. That was my own –

Steven Lane – Sutter Health – Member
It's not that big, really.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
But, we can have that discussion. Maybe under that bullet, we should say, "Do we need to know whenever the data element has been edited?", or something like that.

Steven Lane – Sutter Health – Member
We need to know historically, yeah. Good question for the HITAC. Is this an appropriate future direction for provenance?

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

Yeah, let them figure it out. We're working hard enough. All right. We're making progress. We've got 11 minutes. Where are we? "Clinical notes." Adopt, adopt, adopt. We thought all the notes were good. And then, in our little consensus group, we said to add all the other HL7 document types.

Steven Lane – Sutter Health – Member
They're CCDA document types, right?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right, CCDA. And then, per our concerns that we may not have adequate standards for the following three document types, but they are important, and if we had standards, we should advance them – that was the med list –

Steven Lane – Sutter Health – Member
Now, Terry, remind me. LTS – is that a thing that's a defined note type, or are you just…?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The IG is going through ballot as we speak at HL7. So, it will come out –

Steven Lane – Sutter Health – Member
And, that's what it's called, or are those different ones? Is it long-term services?

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Supportive care plan – so, it's a long-term services and supports care plan note.

Steven Lane – Sutter Health – Member
Okay, good.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. Moving right along. So, we're just saying we should add all the other stuff, so put in "consolidated CDA" before that, too. Basically, the point is that other people besides the eligible providers have data needs, and the original selection of notes wasn't quite good enough, and then we call out the new proposed notes individually.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
That looks good.

Steven Lane – Sutter Health – Member
Shouldn't that third sub-bullet be on top? That's sort of related to including all the CCDA document types.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Right, okay. So, we'll move it up under the first bullet.

Steven Lane – Sutter Health – Member

And then, in **[inaudible] [01:19:50]**.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, got it. So, we'll just ask the HITAC what they think.

Steven Lane – Sutter Health – Member
Here, again, you want "CCDA" added.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. "Pediatric vital signs."

Steven Lane – Sutter Health – Member
I had a chance to review this with the experts from Epic yesterday as well, and again, they were thinking about it in the same way that we are. The only one that's really a vital sign is the head circumference. The BMI and weight for age are simply arithmetic calculations based on vital signs, and the percentiles – whether it's for BMI or any of the other vital signs – are all derived, and it really makes sense for us to include the head circumference, but they felt that derivation – doing the math and doing the derivation – was best left to the receiving system, which is a little different from where we ended up last time, which was saying that it adds context for systems that don't do that.

But really, their point as developers was to say that this is not hard. That's not hard computer programming. A junior computer programming undergrad could write the code to calculate weight for length, and a senior could do the percentiles. Any PHR, nursing, or homecare system should be able to do that, and they felt it made more sense than making those data elements – forcing vendors to store them, send them, receive them, and management. They felt it was a lot of burden for little benefit.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, if we go to the next slide – oh, do we need public comment? Are we at that time?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Yeah, we should probably break now since we only have six minutes left in the call.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. Let's ask for public comment and come back while we're waiting.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Okay. Can you open the line?

Operator
If you'd 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'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 *.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
And, do we have any comments in the queue?

Operator
Not at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
All right, Terry. Back to you.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
So, let's go back to the previous slide, or wherever we were. "Pediatric vital signs." All right, so, these are our recommendations. We said if you're not going to omit weight for age per length, at least correct it to what it should be. Next slide? I don't think there's anything on there we care about. And then, this is just a point to make sure it applies to all age groups – the USCDI vital signs list. It's not a big list. And then, the next slide?

Steven Lane – Sutter Health – Member
Well, could we add one – or, maybe it goes on this slide – the notion that percentiles are valuable, and when and if we feel they should be calculated and exchanged as calculated values, they should be applied to all vital signs, not just to select groups.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do you want to add that?

Steven Lane – Sutter Health – Member
I think so.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
The preamble to that is "Calculated values are important, and when and if they're felt to be required, they should apply to all values." So, calculated values such as percentiles and BMIs…

Steven Lane – Sutter Health – Member
Percentiles for – yeah, percentiles for age and gender – all the percentiles are age- and gender-based.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay, sure. That sounds good. Next one? This has highlighted our divergence of opinion, but it sounds like Steven, you're coming to the "raw data only" group.

Steven Lane – Sutter Health – Member

Yeah. I see the argument when you think about the burdens and the benefits. My thinking was it would be hard for a homecare system or PHR to do that, and I was convinced by developers that that was no big deal. If they just have the raw data, they can do all the things that are needed to do with it.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Even personal health records – someone's going to build the app for that. Is that it? Is that our last slide?

Christina Caraballo – Audacious Inquiry – Co-Chair
I think so.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do we have one more? What's that one?

Christina Caraballo – Audacious Inquiry – Co-Chair
"Raw data versus calculations."

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Do we need to ask them that or not? We can ask them. It's okay. And, what's this one? Oh. So, this is in the "other" stuff. We're thinking about provider demographics. And then, Steven, after the phone call, I talked with Rich Antonelli. I don't know if you know Rich, but he raised some interesting things about some other pediatric measures that aren't really vital signs, but are core pediatric measures. So, I threw those in.

Steven Lane – Sutter Health – Member
You're saying these are quality measures.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Yes, part of the Medicaid…

Steven Lane – Sutter Health – Member
Right. So, I guess the question is if he's saying he wants to know that they were done or if he wants to actually know the results. Hearing screening? Yeah, that's important. Developmental assessment is important. Vision screening is important. I don't think they belong in USCDI Version 1, but that's a really good point, that in the future, those are very appropriate considerations to add.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
And then, the last was the standard quality query response template.

Steven Lane – Sutter Health – Member
Right, which gets at whether those things were done as opposed to what the results were. So, you might flip the order of those. So, whether the quality metrics were performed, and then, the measurements would be the contents thereof. So, it's not about "done by" – I would take out the "by 3 months" or at "at 9, 18, 36" and "by 34." I would just say, "Hearing, screening, and development

screenings." Those are Medicaid-mandated pediatric measurements, and they should be added to the USCDI when we can.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
Okay. So, we'll take all the timestamps off – or, all the time qualifiers. All right. Great. We'll get more room on the fly, too. Excellent. Okay. And then, Adam, just flip Bullets 2 and 3 – flip the last two. Okay, great. I think that's it. We're one minute over.

Steven Lane – Sutter Health – Member
Great. Thank you, guys.

Christina Caraballo – Audacious Inquiry – Co-Chair
Thanks, everyone.

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

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

Valerie Grey – New York eHealth Collaborative – Member
Thank you.

Terrence O'Malley – Massachusetts General Hospital – Co-Chair
All right. See you Wednesday.