Health IT for the Care Continuum Task Force (HITCC)

Transcript
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Virtual Meeting

Members/Speakers

Name	Organization	Role
Carolyn Petersen	Individual	Chair
Chris Lehmann	Vanderbilt University Medical Center	Chair
Aaron Miri	University of Texas Austin	Member
Steve Waldren	American Academy of Family Physicians	Member
Susan Kressly	Kressly Pediatrics	Member
Chip Hart	PCC	Member
Lauren Richie	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator for Health Information Technology	HITAC Back Up/Support
Stephanie Lee	Office of the National Coordinator for Health Information Technology	Staff Lead
Samantha Meklir	Office of the National Coordinator for Health Information Technology	SME
Zoe Barber	Office of the National Coordinator for Health Information Technology	Back Up/ Support
Al Taylor	Office of the National Coordinator for Health Information Technology	SME

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning everyone and happy Friday. Welcome to the Health IT for Care Continuum Task Force under the HITAC. This is our third meeting and we will start with a brief roll call, and then we'll have a few welcome remarks, and then get into our discussion on our draft recommendations to date. So, Carolyn Petersen?

Carolyn Petersen – Individual – Co-Chair
I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Chris Lehmann

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Do we have Aaron Miri yet? Hopefully, he will join us later. Steve Waldren?

Steve Waldren – American Academy of Family Physicians – Public Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Chip Hart?

Chip Hart – PCC – Public Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And Sue Kressly?

Susan Kressly – Kressly Pediatrics – Public Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. I will hand it over to our co-chairs to get us started.

Carolyn Petersen – Individual – Co-Chair
Good morning. Welcome everyone bright and early on this beautiful Friday. I'm really glad we are able to convene again to continue working on the pediatric recommendations and have some good discussion today. And I'll pass it on to you, Chris.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Good morning, Carolyn. Good morning, everybody. We managed to work through three recommendations last time. And we, as a group, have a requirement to report out to the larger HITAC group next week, so we'll do some expectations and we'll do some expectation settings in a few moments. I appreciate everybody being there, and we'll try to tackle at least as many recommendations today as we did last time. Sam?

Samantha Meklir - Office of the National Coordinator - SME
Hi. Good morning, everyone. Thank you for all of your time and input. And I just want to thank and knowledge the robust discussion from last week's call. And we're excited about the discussion today. As Dr. Lehman indicated, soon there will be a report on the work and recommendations to date of the task force. And so, I believe last week we had discussed – with anticipating that we will likely not work through the remaining seven recommendations on today's call and anticipating that the workgroup members are comfortable with indicating preliminary support for the ten recommendations, what we wanted to do is open the floor at this time to identify if any task force members anticipated wanting to recommend removal of any of the ten recommendations.

If not, then next week, what we'll – they'll present on the progress to date with a concrete recommendation for those that have been explicitly discussed and supported. And then indicating the anticipating of the remaining recommendations. Does anyone anticipate not wanting to recommend any of the ten recommendations to bring to the group's awareness at this time? If not, then what we will do is proceed to move on to recommendation four.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
And Sam, I just wanted to chime in here and say that you pointed out that it was a robust discussion last time. And this group was not shy about adding limitations or narrowing the scope of the recommendations to things that are technically and socio-technically feasible. So, knowing that about this group, at this point, I would like to express my support for the remaining – for all 10 recommendations with the caveat that we will make sure that we follow a similar process for the remaining seven.

Susan Kressly – Kressly Pediatrics – Public Member
I'm totally comfortable with that. I think they all belong here. The devil is going to be in the details.

Chip Hart – PCC – Public Member
Yeah. I think each one is a good, broad philosophical idea. My objections would only be related to implementation. Everyone wants immunization registry interaction. It's just a matter of how we're going – what requirements we are going to put into place.

Steve Waldren – American Academy of Family Physicians – Public Member
This is Steve Waldren. On that, that was going to be the only one I wanted to have a conversation about was recommendation five. So, my understanding— and please correct me if my understanding is incorrect. But my understanding is that there is not a freestanding certification process for the pediatric EHR, but rather than that, it's an optional addition to the certification process. And my understanding is the immunization registries are part of the certification process. So, I was trying to figure out what's the difference between this and what's generally required for any certified EHR technology.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Thank you. So, this is good. So, what I read the room as is that there's general agreement with the tenets of the recommendation, that there clearly are concerns in the details that we hope, as a group, will be able to reach consensus on, and then the differentiation between the general immunization requirements and the pediatric specific. And yes, Steven, you are absolutely right. This is voluntary – we are working on a voluntary certification for pediatric EHRs. So, this is in addition to the certification that EHRs are going through anyway.

Samantha Meklir - Office of the National Coordinator - SME
Thank you. So, this is Sam. I would just offer that – two remarks. Much of the discussion around the implementation of the recommendation in practice, all of these comments will be retained, noted and shared as part of the presentation. And we will aggregate them as an implementation consideration with specificity that correlates to each recommendation that is discussed. And then to note that the recommendation is concrete, as contained in the NPRM. And the discussion regarding the implementation in practice will be noted as implementation considerations, much of which is laying the path forward for the work to be done for the success of this in practice as informed by stakeholders and ONC.

So, we can explore that further. I believe our Deputy, Beth Myers, will be joining us as part of this call. And so, I will turn it over to her at that time when she joins us to offer some welcome –

Beth Myers – Office of the National Coordinator- SME
Hi, Sam. I'm on. I had a little bit of technical difficulty this morning. I apologize, everyone. Yes, I am on now.

Samantha Meklir - Office of the National Coordinator - SME
So, I just was teeing you up. So, let me turn it over to you.

Beth Myers – Office of the National Coordinator- SME
Okay. Excellent.

Samantha Meklir - Office of the National Coordinator - SME
And I don't know if you were able to hear some of the earlier comments of Dr. Waldren or Dr. Lehmann or if you just hopped on?

Beth Myers – Office of the National Coordinator- SME
No, I did hear that. I didn't want to interrupt. I heard – just as Chris was beginning to speak is when I finally managed to get things to sign on. So, I think it's an excellent –

Samantha Meklir - Office of the National Coordinator - SME
[Inaudible] [00:07:46]

Beth Myers – Office of the National Coordinator- SME
Sure. It's an excellent segue. I wanted to – so, I've had the – I'm super excited to get to join the task force today. I know I haven't been able to participate in the prior meetings, but I have listened to them and read through the notes. And I just wanted to take a minute to provide some context about how we

got to the space that we got to with the pediatric Health IT. And for those who may have been at the annual meeting, we had a session where we sort of talked about broadly the sort of – the evolving role of ONC, but also some of our other federal partners in trying to fill these gaps to work through how Health IT can better support the entirety of the care continuum sort of beyond **[inaudible] [00:08:34]** is a phrase that keeps popping up when we talk about this.

So, I wanted to take an opportunity just – I'm going to go as quickly as I can, because I know we have a lot to get through today. But to maybe give some framing and context that might be helpful. Some of you have probably been part of the conversations. Some of you, it may be a little newer and a little different than how we've talked about things. The construct that Chris has described is absolutely right. So, for the rule, what we have to do is sort of go to the statutory authority and set these recommendations and identify the specific certification criteria that will be adopted under this construct – a voluntary certification for pediatric health IT. But how that fits into the broader context – and we do have – I think we have a tip sheet now that helps to sort of describe this too.

We know that that's not the end. Right? We know that that's not the limit to the chain or the limits to the need. And that I think you'll hear Steve Posnack say over and over again that we view certification very much as a floor. So, the way we've kind of begun to evolve this process and sort of describe this process is essentially a three-part construct where the first part is very much in line with the recommendations that have landed in the rule and are landing in your lap. The idea of there are ways that Health IT can support really big, broad things. Like we say Health IT supports care coordination or we say Health IT supports patient access. And those the big, broad things and that's wonderful. But contextually, we really need to be supporting clinical priorities. We really need to be supporting the clinical needs of care providers in the care setting.

So, that's sort of that first part, that thinking through what is the clinical priority that Health IT can facilitate that is a care improvement goal or a care need that, on a daily basis, we do X thing that is absolutely essential to providing care to our patient population and we Health IT to support that better. So, that's sort of part one, and that's what you see reflected in those recommendations, which came from work with stakeholders. They came from prior work in the children's EHR format and sort of coalesced around here's these ten that we're hearing very loud and clear, clinical-related recommendations.

So, the second part for ONC's point of view is the certification program. What can a certification program do or what does it do? And how do those functionalities that we are setting as here's the floor that everyone must have that can be supportive of those clinical priorities of those recommendations? And then from there, how can we build upon that or how can we ensure that floor fits the room in which it's working? That's really the third part and the third idea of the construct, that there is work that has to come beyond the certification program. There are limitations that need to be informed. There are – I know there was some discussion in the last one where someone sort of specifically mentioned that it sounds like a lot of this is future work. I think it was in relation to some clinical decision support constructs as well.

So, there are these other pieces that need to fit into the tech in order for it to work appropriately in the setting. They might be implementation guidance. They might be specific thoughts around how you view training and workflow. They might be tools or resources like – I'm not going to name any specific ones, but we all know probably what everyone's talking about. Bodies of work that are really robust clinical decision support that need to be electronically transformed so that they can be easily

accessible and dynamically used, not as just a pop-up but as a useful tool within an EHR. So, we really see that third part as a collaborative effort as well, similar to the first part of setting the clinical priorities in the first place.

So, a lot of these really informative, deep implementation pieces that we are talking through – that you've talked through so far, that we're going to be still talking through today – informs that work. They are that future direction work of how we work together to build this. How does Health IT inform ONC? But also, from several partners, we have an opportunity to work with them, and inform them, and help them be setting policies that support this as well. And how does the industry come together around these ideas? That's a really essential part of what you all are doing is putting in a very important public forum that is the Federal advisory committee the thoughts and these pieces behind the what comes next and what is the unique implementation here.

So, I hope that helps sets some framework so you can kind of see how the three pieces of what you're talking but also align with the three pieces that are – it's a sort of simple construct to try and describe a complicated process. But that's sort of what we envisioned. So, I don't want to discourage anyone from talking about those deeper implementations that are more unique, but I do want to make sure that we're capturing the idea of the certification as a floor upon which these other things that may involve future work or that may have current existing things that need to be considered are sort of building so that we can have that framework for context. With that, I will stop taking up time that should be done with discussion and pass it back.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Thank you, Beth. This is Chris. And I think that this was very helpful for level setting and expectation setting. You know, while you are already thinking at the third phase on how to improve upon it, I just started thinking about the second phase about the actual certification implementation. And I actually happened to talk to one of the certification bodies yesterday about how the use-case development for these recommendations is the next big work effort that needs to be done. So, this is really helpful to put it in perspective and to remind us that yes, what we are doing today is the basic, minimum requirement for pediatrics. And we will have to build upon it, both in the making this actually actionable for the certification process, but also in tightening the screw going forward.

I think I want to remind us that we are the first group that worked on the specialty-specific certification, so our example will have a big impact on other specialties that seek a specific modification to certification as in regards to their specialty. So, people will look at this, so it's important that we get this right.

Beth Myers – Office of the National Coordinator- SME
That is a no pressure statement, right? But I – no, I will say we sort of feel that way too. We're excited. This is a really – has been a really wonderful process and a really good learning process for us. And so, I do want to – I very much want to thank you all for joining and being part of this, and for the work that has gone into it. Because to Chris' point, this is a model for how things can go and could be thought about to try and get beyond the sort of – I'm going to say it again – but the statement of the beyond the meaningful use and how do we support things beyond the sort of baseline things and make sure that they work. I will again stop, and we can't get into the meat of the discussion.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair

Thank you. I think the first item today, in regards to the recommendations, is for us to talk about recommendation number four. I suspect this is going to be challenging and so will be five. Recommendation four is the segmented access to information. The descriptor for this item says, "The system shall provide users the ability to segment healthcare data in order to keep information about minor consent services private and distinct from other content of the record such that it is not exposed to parents or guardians without the minor's authorization." And the last time, we talked about the fact that we used to think about this in the context of reproductive health and sexually transmitted infections. But in this day and age, it actually goes beyond that. I reminded you of the young man who testified to Congress about obtaining immunizations against his parental wishes. So, these kind of things are things we need to consider as well.

So, I will just go ahead and open the discussion and see what concerns or restrictions you have about this particular recommendation.

Steve Waldren – American Academy of Family Physicians – Public Member
This is Steve Waldren. I think the challenge is really in the implementation. I would assume that you are going to talk about just having a shadow chart that's part of the record. Otherwise, it's difficult to say. Like those immunizations, then it's like, okay. Well, then there's no immunizations on the immunization list or for problems – just the notion of it being able to bleed out into other parts of the record, since we don't have the semantic definition enough for the EHR to be able to know that anything about immunizations shouldn't be included.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. I think this is a very good point, Steve. So, how do you actually implement this? Because the challenge is not just in what is in the chart, what is on the portal, but also what gets sent out in the form of billing information. I mean, I'm always – you know, I'm the father of a 21-year-old daughter – 22-year-old, sorry. And when she seeks healthcare services, I get the bill. That bill comes to me because she's, as a college student, still enrolled in my health insurance. Now, I make a point of not looking at it. But the issue extends to the billing as well and to what insurance carriers do with the billing information on their end. So, this is actually – this is an issue that goes beyond the EHR but also goes into the issue of insurance and how it is provided.

As for the EHR, my vision would be that this would be – that one possible solution – and I would love to hear pushback. That one possible solution might be to tag data as confidential and then based on that meta-tagging, that the information is handled differently when it's being released or when it's sent out. So, I'm going to stop here and see what others think.

Albert Taylor – Office of the National Coordinator - SME
Chris, this is Al from ONC. What you just stated or just asked as a potential solution is really at the core of what the DS4P standard proposes – that any particular data could be tagged with not only privacy, view privacy, but also share privacy or re-disclosure. And those security standards are well established, and they are the same security standards that are part of the current data segmentation for privacy standard, but those only apply to the CCDA document. But because we only adopted part of that HO7 standard, the DS4P standard. So, what you're talking about is exactly the proposed solution. But as Dr. Waldren pointed out, implementation is the devil.

And some of the data elements may not have – you know, currently don't have the metadata fields to handle them. Some of them don't. And so, that would require some remodeling of some of the data

elements, particularly the ones that don't already have – like immunizations may not have – currently, the data fields may not be able to hold privacy security tagging. But other ones that are more typically associated with privacy security concerns may have. But it might well require a significant remodeling in implementation.

[Crosstalk]

Albert Taylor – Office of the National Coordinator - SME
All that said, there are pilot implementations of the full DS4P standard to use as a guide. So, that's – I'm going to throw that out there.

[Crosstalk]

Samantha Meklir - Office of the National Coordinator - SME
This is Sam. I would just – in reference to Al statement, just alert folks on the worksheets, if people have those handy, for recommendation four. When we look at alignment with proposed new or updated certification criteria, the second and third bullets delineate the data segmentation for privacy proposal in the rule that is not in the Care Continuum section in the other part of the rule. And as the task force members recall, in addition to discussing this specific recommendation, there is also – part of the charge in the scope of the task force is regarding the recommendation put forward on data segmentation for privacy in the rule itself. Once again, **[inaudible] [00:24:03]** second and third bullet of the technical worksheets under a line proposed new or updated criteria. Sorry for interjecting that. I just wanted to give folks a reference. Thank you.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
No, that was very helpful, Sam. And thank you, Al, for referring to that, because I think that's definitely a – the data segmentation for privacy is, I think, a great path towards achieving this recommendation.

[Crosstalk]

Susan Kressly – Kressly Pediatrics – Public Member
Go ahead.

Chip Hart – PCC – Public Member
Sue, I suspect you and I are going to say the same thing, so you go first and I will see how far – how much we differ.

Susan Kressly – Kressly Pediatrics – Public Member
I think we over-talked Steve. Steve, you had something else to add?

Steve Waldren – American Academy of Family Physicians – Public Member
Oh, I was just going to say – I mean, just to be clear, I agree with focusing on this. I think the challenge is that one, is it only that I put things in a consolidated CDA that it would be up for segmentation? And then the other question is kind of from the semantics. Well, what is a data element? Is that a clinical statement? Is that part of the narrative normative part of the Consolidated CDA? Is it the entire normative text? Or is it a paragraph, a sentence, a word? So, I think the challenge is that you may be able to put it all in a consolidated CDA, but then if it is sitting in a paragraph and something or, like Chris talked about, goes out through a bill, then you have that leakage. So, then you have this false

sense of, “Oh, well this is secured information where it’s going to leak out kind of all over the place.” But I agree with Chris in regards to that is the right way to implement it. But then at what level of granularity is that tagging? Is it individual words and HER? And that becomes a nightmare, unfortunately, for our folks that are trying to build these types of solutions.

Susan Kressly – Kressly Pediatrics – Public Member
So, this is Sue. And I would caution us to not get stuck in the perfect end goal because we’ll still be having this conversation in ten years. I wanted to solve it ten years ago, right? I think the right answer is that we start to lead EHRs to be able to protect granular data elements in their system so that it doesn't – and we don't have a standard for it yet of like do you do it by clinical user role et cetera. But we should agree that the EHR should have some way. And I don't think you should get the word level, but you should certainly get to the major sections of if it’s a problem list item that is sensitive, on the chart, you have the ability to protect it there and when it goes in the CDA. Because it's not just when it goes to other places, it’s also within the EHR. You know, if an adolescent wants to disclose to me that they had an abortion and not have their father the neurosurgeon see it, we should have the ability to do that on the chart level and then also talk about data exchange.

And so, what I would say is that we should look for something that says, “The EHR should have the ability to protect granular data level at the element level.” Don’t hide the problem list. Hide that specific problem. Don’t hide the med list. Hide that med. And if you have – and if an EHR – you know, people are dictating notes, have the ability to make that note sensitive. I think it’s – we are not quite ready to talk about what happens in billing data. And I would like to start the process moving forward here. I also think – and I would love to hear from the ONC folks – does DS4P also have a standard nomenclature that says something in this section has been withheld so I, as the clinician, know to go to the patient and close the door and say, “There is something on your problem list that’s missing. There's no one else in the room. What do I not know that I should know about you?” Is there a standard for that in that standard?

Chip Hart – PCC – Public Member
Actually, Sue, you did say some things similar but some different things that I was about to hit on if that’s okay. I think the focus on the CDA is great, but the privacy issue goes far beyond that. I mean, we’ve bumped into it a little bit. But first of all, we have legal standards that aren’t defined. You know, in the state of New York, you’re required by law to put the diagnosis on the bill. And then you're also required by law to protect adolescent privacy and hide that diagnosis everywhere else. And so, as the vendors who are trying to merge these things together, we create impossibilities all the time. So, one thing that we need to get our heads around is the lack of legal standards.

I also think, more importantly, even if we have a way within the data to identify those things which are private, and which are not, and so forth, I think the UI issue here is insanely enormous. To go to look at any typical pediatric chart now, which is fairly standard and straightforward, and realize that we might be able to segment it all the way down to individual problem list items or maybe even that the kid got an HPV shot – to create a UI that would allow that level segmentation and then within that segmentation, indicate from a long list of care providers – because that’s the item just above here – who are allowed to see this thing and who’s not, depends fantastically on users in a way that it will never – I don’t think it’ll ever actually work well.

And if you talk about whatever, you talk about the burnout that we’re getting from EHR users. Take chart note and overlay some sort of privacy template on top of that – on top of it with hundreds of

opportunities to click and unclick things based on the granularity that you want for privacy. That scares me a lot. And I'm not saying that's the only way to do it. I am perfectly familiar with how to make a lot of those things easier and better. But I think what we are basically doing is looking at the clinicians and saying, "You guys are going to bear the biggest burden of what is going to be considered private. And you're the ones who are going to get in trouble if it's wrong. You are the ones who are going to have to be the perfect gatekeepers of it." And from a UI perspective, I'm really worried.

And this comes up a lot. Sue and I deal with this very differently than I think a lot of other vendors do when it comes to – because of our patient portals. Most vendors just simply lock down patient portals and say, "Okay. Each patient has an individual record." And they resolve – that's how they resolve segregation of clinical information. But when you're dealing with pediatrics, you're dealing with family records and you're dealing with a single parent needing instant access to each of her four kids not having to sign into four different portal records. And to suddenly segregate some data within – you know, her daughter turned 16, and suddenly some data is segregated. That becomes really tricky from a UI perspective. From a data background perspective, it's actually a little more academic.

And so, I hope that makes some sense. I agree with Sue. I'm not throwing – I'm not suggesting we throw this out. I want to find those places where we can get better with this data privacy segmentation. But until we have some better legal standards and some better clinical understanding of what is appropriate, I think this one is going to be a struggle to do well for a long time.

Susan Kressly – Kressly Pediatrics – Public Member
Can I go back to the question from the ONC?

[Crosstalk]

Beth Myers – Office of the National Coordinator- SME
Yeah. This is Beth. I was going to come back to that, but I wanted to make sure I wasn't interrupting any further discussion. So, I think that we probably need a little bit more expertise on the very granular work around DS4P, although Al may be able to provide a little bit more context than I can. But I wanted to start from a high level of it. The DS4P standard from HL7 – so, it is CCDA-based, but that doesn't mean that it only can live as a CCDA move. So, it is a tagging mechanism and a tagging protocol that allows you to put metadata tagging within the system that can then be part of what is exchanged through a CCDA.

We did also propose in the rule one fire-based solution, which is another ancillary piece. There are lots of folks who are exploring API solutions to this that get to some of what – and I apologize. I didn't recognize the voice to know the name – what the last commenter was talking about as well. For example, if you have a parent with multiple children and you have these different pieces that are tagged, how does that work when you have multiple records in multiple portals? And how does that change that dynamic? So, we are looking specifically at the consent to share a resource in the rule. There are other tools that are being developed that are like this that essentially allow you to use an API to pull that data to manage consent and do more dynamic things with how you're re-aggregating that data, or using that data, or potentially putting that data with other sources of records or using it for another purpose.

Because remember, apps don't have to just be the apps on the patient's iPhone. We expect there to be a thoroughly rich app environment that supports providers as well. It is one way that you can sort of

turn the database of an EHR into something more dynamic for specific use cases is to think about it that way. So, we are learning that in the rule as well. To the last commenter's point, there is a lot of other work that is not text work that needs to be understood and better fleshed out, I think, for everyone's benefit. The variance in state laws is a really significant example. When we look on the OUD side, part two conflict to state law conflict to HIPAA conflict with all of the different privacy and security options out there. That is why, within the rule, we did try and narrow the focus of the two criteria, which is why they've been put on your laps as opposed to one of the other task force groups to really think through, "Are these tools if we're at least narrowing to the use case of pedes" – which I recognize is still a huge use case, but it is less than all patients all the time, right? – "is this a more feasible thing for developers to start digging in on and coming up with ways to get from where we are, which is that providers are still responsible for this and have to do it by hand, to where we want to be, which is that machines are exercising the rules for providers and providers are sort of the quality check to make the intelligent decision about it or the rational decision about it, but the machine can follow the rules?"

So, that's why it's here. But I hear what you're saying about the specific questions on exactly what the standard can and can't do. It is a tagging standard. It is based on how to tag the data itself. So, some of the more dynamic things it, by itself, isn't going to trigger clinical decision support to say, "Don't disclose in this particular instance." But it could be used to build such a thing. So, I think that might help to frame where this piece fits. And I hope that we can think a little bit about where that fire construct might fit as well.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Thank you. To get back to the limitation or restriction of this recommendation, are there any suggestions from the group of how we – what kind of fence we should put around this problem and say, "We want to use this for this particular space" – let's say for portal use – or, "We want to use it for CDAs only"? Are there any thoughts about how we could limit this recommendation so that it becomes implementable?

Susan Kressly – Kressly Pediatrics – Public Member
So, you're looking about where the data is going. I'm looking about where the data is tagged. And I'm going to push back on Chip a little bit because it is the relationship of the provider with the patient that has to make the decision about what's shareable. That is not something that we can give to anybody else, in my opinion. Eventually, you may get to the point where the family or the kid – but then it's harder in adolescents, right? Because when can the parents decide and when can the kid decide? And we're not going to change state laws. But I would like to see this say that the EHR does allow access at the user level to tag an individual problem list item, an individual medication, or an individual note. I think you pick like four or five big things as protected. The user can protect it when they enter the data in some way. And we can get specific about using the DS4P standard, as I have to admit I didn't read the whole thing and probably can't.

And as a step to then not – and then use that tagging to not have it show up in a CDA, or a portal, or an exit note that you give to another provider, right? That you print out. So, just saying that you're tagging it as – you know, pick the big five. I don't care. Let's start at the CDA, right? Don't hide the whole CDA, but the five sections. And it's a place to start so we can start getting people to think about it. Not only do they have to let the user restrict its privacy in some way, but also then when they run a report, or send a CDA, or it goes to the portal, that privacy is respected when you're exchanging the data in another place.

And I would just say that. Right? Like, let's not get to the point of what goes to a CDA and what goes to whatever. If a user wants – because we can't protect it on the other end yet. It shouldn't go, is my opinion. Anything that the clinician user decides is sensitive enough to tag we should protect from being sent because we can't protect it on the other end yet.

Chip Hart – PCC – Public Member
Yeah, and if I could just add, I think Sue's suggestion here of picking some of the obvious items first and getting some sense of how they work is a good one. Obviously, protecting immunizations – you know, Dr. Lehman, your example's a very timely one. But as we know, for every one of those, there are 10 million immunizations that don't need privacy. And it's sort of a – that's an edge case. And so, I think – and I know you didn't mean it that way. And so, I think –

[Crosstalk]

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
I wholeheartedly agree with you. There are other things that are more important.

Chip Hart – PCC – Public Member
Right. However, the thing I'm trying to avoid, Sue, is a bunch of nerds – and I'm calling all of us that but maybe I'll just call myself. But I mean that in a nice way. You know, a bunch of people in a room saying, "Hey, the way that we're going to solve this is by allowing a discrete ele— for every discrete element in the HER, the user, the clinician, the doctor can go in and choose from among the eight care providers who are linked to this patient and individually decide for each element which combination of eight care providers should be able to see these elements." I know that's not what people are suggesting, but I also know from a lot of software development that's exactly what happens with too many decisions like this.

[Crosstalk]

Susan Kressly – Kressly Pediatrics – Public Member
Is there something in the DS4P which talks about a clinician level of role? Like a front desk versus clinical user versus provider versus whatever? Most **[inaudible] [00:40:51]** have some – like, there's no standard there, right?

Beth Myers – Office of the National Coordinator- SME
The standard is agnostic and could theoretically even be done – like, if you built a way to do it, you could have a patient who is identifying things for tagging. It's about the tagging portion.

[Crosstalk]

Susan Kressly – Kressly Pediatrics – Public Member
Go ahead, Al.

Beth Myers – Office of the National Coordinator- SME
Yeah, Al.

Albert Taylor – Office of the National Coordinator - SME

So, your point about – so, no, there's not a way to – this is about the data itself. This is about marking the data. What happens once you are able to mark the data, that can rest within the EHR. It's what happens next. It's the rules that are applied to those data, whether it's, "What do we put into a CCDA?" or "What do we display on screen?" We only display the last 30 days of meds, or we only display untagged data elements, or we only display CDCs and not CHEM-7s. You know, it's the rules for display and it's the rules for sharing that is really probably the hardest part, probably harder than, "What we call this? How do we tag a data element?"

So, the rules about how those tagged data elements are used are not part of DS4P. And that would be part of that implementation is the rules are, "If you're a PA, you don't get to see it. If you're an MD, you do." But the rules act on those tagging elements.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
To jump in here quickly, I think the reality in the world as we live it right now is that pediatricians are dealing with this problem every darn day. Anybody who takes care of adolescents is exposed to this problem. And what the proposal on the table here says is, "At least, let's introduce a tagging standard that allows various people, including the patient herself, to tag information as privileged and confidential." And with that ability, I think the downstream work of how to manage it will evolve pretty much organically. Once you have the ability to tag information, the managing and handling of it will follow suit. So, I think that we should focus on the proposal on the table. Is this something that we really want to see?

Susan Kressly – Kressly Pediatrics – Public Member
Yes. I want to also go back to the question I asked that was an answered, which is, is there standard nomenclature that says – along with the CDA that got sent that's got protected information, to tell me, as an end-user, that there is protected information that I'm missing? So, I'm not – because that's a patient safety issue to me. I don't want to make an assumption that I'm seeing the whole thing when I'm not.

Steve Waldren – American Academy of Family Physicians – Public Member
Yeah. This is Waldren. That's a conversation that gets to be kind of a circular conversation in the privacy piece. Because of the fact that you know something's missing can help you try to figure out what that piece is that is missing. So, there are some people that say that even knowing that something is missing is a breach of privacy and shouldn't be known. I mean, from a clinician standpoint, you always assume that you don't know everything and that there could be something missing. But I don't know if it's in there, but that does get into a whole other can of worms.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. And Sue, I think from a – if you're concerned from a liability issue, I think if you don't have something in your chart, then you can't be held accountable not acting upon it. That's my approach to that. And I – this is a function of privacy. You know, it's a tradeoff that is chosen by the people that ultimately do the tagging. So, I think I – I don't think I would worry about it as much as you do.

Albert Taylor – Office of the National Coordinator - SME
Sue, this is Al again. I don't know the answer to your question. I think – and I will check on it and I'll get back with the group at our next meeting. I do believe that the answer is no. It has to do with – whether or not it's suppressed or not has to do with how the display is rendered. So, if you're rendering a CCDA, that sort of notice of suppression may be produced as part of the rendering of the CCDA. But I'll get

back to the group on whether it's in DS4P or whether it's in CCDA. I suspect it may be in CCDA, but I'll let everybody know.

Susan Kressly – Kressly Pediatrics – Public Member
Thank you.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Let me sum up the discussion so far. I think what I heard is that the overall recommendation from this group is that this is a huge piece – this recommendation by itself, a huge piece, and we need to narrow it down. And the recommendation at this point is to, more or less, on the notion that we want to have an ability to tag information as private. And that we, at this point, not worry about what is being done with that information, but that we introduce a way for information to be and labeled such so then vendors, and pediatricians, and family practitioners, and who else can determine what to do with that information downstream. At this point, by themselves. And at a later point, we hope we'll have the ability to fine-tune this and also come up with the recommendation about the transmission and sharing of these data elements. Did I sum this up correctly? Did I meet the – I don't hear any violent objections.

[Crosstalk]

Susan Kressly – Kressly Pediatrics – Public Member
I agree with the spirit of what you said.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
All right. Okay. So, are there any other topics, any other issues that people want to raise in the conjunction of recommendation four? If not, then I would move on to five.

Samantha Meklir - Office of the National Coordinator - SME
Chris, this is Sam. Just from a procedural perspective, the group is supporting or recommending recommendation four for inclusion. And is there any correlated criteria identified that anyone would suggest removing as a correlated item identified at this time?

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Thank you for keeping me on the straight and narrow.

Samantha Meklir - Office of the National Coordinator - SME
Sure.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
You are talking about the aligned item in the criteria, right?

Samantha Meklir - Office of the National Coordinator - SME
Correct.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
So, that is the data segmentation for privacy. There is the coordinator interoperability thing, data segmentation proposal – we talked about it – and application program interfaces. So, those were the things that were linked to this.

Steve Waldren – American Academy of Family Physicians – Public Member
This is Waldren. Chris, based on your summary, I think the transitions of care in the API may be ones that would not apply if we are talking about just tagging and not talking about use at this particular point in time.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
That is how I would understand it too. All right. So, that means we are off to the next recommendation, which is number five. I expect another robust discussion on this one. Synchronize immunization histories with the registry. The description was, "The system shall support updating and reconciling a child's immunization record with information received from immunization information systems or other health information exchanges." Al, do you want to walk us through the aligned things?

Albert Taylor – Office of the National Coordinator - SME
Hang on a second. Let me just look at the screen so I'm reading the same – so, the standards – this is one of those – this is one of the requirements where the recommendations that we feel like has largely already been met by the existing criteria. So, the correlated criteria primarily included immunization history and forecasting, which is part of the certification – current certification criteria. And the next comment is an implementation comment. But this is a well-established and fairly high-penetration functionality that's in place. And it does apply both to pedes and adult immunizations. And so, I think that I don't have a lot more to say.

And I continued to confirm with our public health folks at ONC that this is a fairly highly-implemented standard for people that are using certified EHR technology. The interface with the state immunization registry is in place and it's in use. And they – and I think that there is no – I don't believe that there any requirement for pediatric immunizations that are not met by the immunization history and forecasting function that's part of certified technology. Now, as I understand it, you can certify EHR technology without certifying to that specific standard. It's one of the pick lists of criteria. But it is very widely used in certified technology.

Susan Kressly – Kressly Pediatrics – Public Member
Except it's really ugly and non-usable. So, the question that I have is, is there some way here that we actually make it functional? And part of this we know. And I know there's a workgroup at ARA on certifying the IAS face of it, because some of the data exchange is problematic on what's coming back and the way they store data. I mean, I've had a bidirectional ability to reconcile for eight years, but it still doesn't work in a way that a user can count on it, which is sad to me. So, the question I have is, do we add some nuance to this that makes it have a little bit more teeth and legs so that users can feel like they can count on it? Now, the new spec goes a long way and ARA trying to get IAS's to certify is going to go a long way to getting there. But do we have an opportunity here to say something about usability? I don't know.

Steve Waldren – American Academy of Family Physicians – Public Member
This is Waldren. I think Alan made my case of why I thought this one maybe could be removed. The only two things – one is this description talks about the reconciliation of the immunization record. So, I don't know that that's part of the current certification piece. But I think the real challenge – and it was starting to be laid out in the conversation that we just started to happen – I don't think this is an EHR problem. I think this is an IAS problem. I just can't see a pediatric-focused EHR that if there was a single API was implementable to do a bidirectional exchange with state registries, that they did not

implement that ASAP. And I don't know that we can do anything to push. Because we're just pushing on the wrong part of the ecosystem here. We need to push on the IAS not on the EHRs.

[Crosstalk]

Susan Kressly – Kressly Pediatrics – Public Member
I'm going to push back in a little bit. Because there are some EHRs where it's done in bulk by some IT person who reconciles and in the clinical user doesn't have a chance to see who made the decisions. And why all of a sudden do I have an IPV and OPV for the same date for the same kid? That's not right. There's something wrong about that. Right? Or I know, for example, that I've seen the CCX code for Hepatitis A granular way to my IAS and they store it in their IAS as Hepatitis A **[inaudible] [00:54:55].** And then they send it back to me that way. And I look at those. And I'm smart enough to know that's – I know what's happening, but my other – my nurse isn't. She just imports stuff, right? Think registry import, which then has a safety issue.

So, my question is there a piece on the EHR that we can – and I don't know what the answer is. I'm just raising the question. This is the right information in front of the right user at the right time problem, right? And do we have the ability in this to say – you know, because some EHRs are swallowing some of the messages that are coming back and not actually displaying them, or they're displaying it to an administrator who logged in once or whatever? You really needed it at the point of care. And I don't know that that's delineated in the current testing requirements.

[Crosstalk]

Steve Waldren – American Academy of Family Physicians – Public Member
– I'd support that fully.

Chip Hart – PCC – Public Member
Sue, I think you probably know better than I do that problem of getting wrong hepatitis back from the IAS. It may have very much to do with this problem about not certifying – the IAS not certifying their vocabulary of immunizations, not having them do things consistently. And so, I think that exploring could be – I think I'll let Beth speak for this. But we are certifying the EHR and the functionality of EHR and not the IAS, which I think pushing on the rope is a pretty good analogy.

Beth Myers – Office of the National Coordinator- SME
Yeah, I think you have summarized exactly right there. That there are limitations to our authority, but we hear you. So, I think that this discussion is the type of thing that does need to be captured. I think with the certification part of it, as Al out pointed out, it's the – where we're on the provider tech end, we do have relationships that work with public health and with states, so there are channels by which the rest of the information does get shared. So, I would not be shy about expressing it. I'll put it that way.

Chip Hart – PCC – Public Member
If I could add one quick thing, I was doing an analysis of the surveillance data is posted on the ONC site. I wanted to see what sort of problems vendors were being surveyed for. And – or surveilled, I guess. I'm sorry. And the number one item was the lack of transparency posting on the website. So, I thought that was kind of funny. But the number two item, the thing that is most attracting the attention of the auditors, is the vaccine registry interaction. I have not dug into it at all to determine what the common

factor is, what the problem is there. But it strikes me that the 2015 certification, as written, may not be – we have some proof that it's not being implemented well.

And so, I'm supporting Sue's position here. Or that there's something to the way that the language is written that is not getting us the result that we want. It is the number one true software-driven item picked up by the auditors, from the data I saw. I also think – we might – I just want to be clear. I am in full agreement with this one. But I think we want to – if we were to make any kind of amendments, I think we really want to drive back to what the reason for this item is. Again, I'm in Sue's place right here. This is about getting that right information at the right time to the right person.

What we're trying to do here is avoid missed opportunities to immunize and occasionally avoid opportunities to over immunize. You don't know better. Those are much less rare. And in my mind or my experience, I will say, that thinking with the state registry is not a huge gain there. It's not. All right? Most practices are pretty jealous of their data, and they're better about than the state is, more often than not. Not always, but more often than not. And the word that's buried in the worksheet that's really important – and it is part of the existing certification – is the forecast line. And that's really the most important item here. And Sue and I both know that that is really, really poorly. And I don't know if – this is major scope creep, and I'm not trying to do that. But boy, if we could somehow shore this up or just get a reminder in here. The goal is to make sure we're not missing opportunities to immunize.

Susan Kressly – Kressly Pediatrics – Public Member
Well, and when you get to the forecast, Chip, we also have a problem in that – and I don't know if this group has any ability to influence it – basic recommendations come out in the MMWR and then there's a huge lag of what this adoption curve is. And it's very variable, right? So, the clinician knows, "When it's in the MMWR, I'm supposed to do X." And you could be getting misinformation from your EHR or you IAS that's not in keeping with that for up to a year or more. And that's problematic to me. So, whether you harmonize timing of updates – again, I don't know how you'd test that or even put that in there.

But it is a patient safety concern in that the other piece of this is – and if we're going to go to patient safety at some point, trainees and young physicians are learning to use the software in their training programs. And they think they all work the same. And so, it's like, "Well, why did my EHR tell me this was kid due for yadda, yadda, yadda?" Right? So, we have to be – and Chip brought this up in the last time. Where are you getting your data from? Right?

Chip Hart – PCC – Public Member
Great point, Sue.

Susan Kressly – Kressly Pediatrics – Public Member
What are you using as your source of truth? How often do you update it? Do you have a contract with your users that you will update within three months of the MMWR recommendations? And what is that source of truth that you're using it from? Just so that people can decide, from the clinical standpoint, how reliable is this? Because it's decision support. This is the most important clinical decision support that pediatricians have. The most, hands down. And if it's not reliable or accurate or you don't know the source of it or how recently it has been updated, that's a big issue.

Chip Hart – PCC – Public Member
I couldn't agree more. I'm totally on board with Sue here.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. So, this is really – this is an interesting discussion to me. Because what this points to is – you know, really what we have been talking about as pediatricians for a while is that every registry, every state registry reinvents the wheel when it comes to the forecasting piece. And they have to do it every year anew. There is actually a great need to have one federal resource to do this. And it kind of seems to be logical to me to have it linked to the people that actually come up with the immunization requirements. But that's beside the point here.

Now, I'm going to go back to the discussion. Essentially what I have heard is that we are doing this already. The certification, as it comes to the existing certification, covers a lot of that. But I also heard that you would love to have something built in there that would push on the existing registries to improve their act. Is there any concrete recommendation that you could formulate that we could add to this? Or is this more of a – you know, we would like them to be better, but we don't have anything – we don't have a forcing function that the EHR could introduce to the registry?

Chip Hart – PCC – Public Member
Well, we have one problem. I'll jump ahead because the natural answer to that, Dr. Lehmann, is, "Oh, yeah. We would really like them all to adhere to the proper standards." But one of the problems that soon I run into all the time is even when you have an IAS saying, "Oh, yeah. We do bidirectional, and we follow the standard," it could be a year before you could actually add one of your customers to their interface list. And we have practices who have been queued up for multiple years at different states. And so, one of the problems here is even when everyone is on the standard, the states have either a lack of interest or lack of resources – it's some combination. It depends on the state – to even allow this to happen.

I mean, it's one of the ironic aspects of this requirement is that even if all the EHR vendors did it flawlessly, which will obviously not happen, the majority of people in the United States or the majority of pediatricians in the United States can't take advantage of it.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. Well, usually at this point, I would launch into a tirade about how pediatrics is the redheaded stepchild when it comes to meaningful use and related issues. But in this case, I can't because this affects adults as well. So, yay. At least they are sharing our pain once that they are dealing with 57 different rules and requirements, right? So, hey, at least we are not suffering alone. Now, that doesn't solve the issue.

So, I think what I hear out of this discussion is a strong recommendation that this might be future work for ONC to look into a way of consolidating these different state immunization registry forecasting models into a single resource that would reduce the amount of time it takes to update immunization forecasting. And also, in some work that ONC could do that looks into the time to onboarding of practices for immunization forecasting and identifying ways of how the federal government can help. But overall, I would say the discussion says that this is a good recommendation, but there is nothing much that we can do to tighten the screw at this point. Is that a fair summary?

Chip Hart – PCC – Public Member
That works for me.

Susan Kressly – Kressly Pediatrics – Public Member
Yes.

Carolyn Petersen – Individual – Co-Chair
Yup.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Okay. Anything related to the alignments that were in this recommendation that you want to add? I will give you the last word there.

Chip Hart – PCC – Public Member
No, I don't really have anything else. No, I don't think so. I think I have already said it.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Okay, thank you. How are we doing on time, Sam? Do you want to give me a check on whether it's reasonable to attempt the next recommendation?

Samantha Meklir - Office of the National Coordinator - SME
Thank you for asking. Lauren and Cassandra? What is your recommendation?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yeah, we have time. We've got like 12 minutes before we need to go to public comment.

Samantha Meklir - Office of the National Coordinator - SME
Great. So, let's proceed with recommendation six.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
All right. Age and weight specific single dose range checking. This is aligned with the recommendation two, I think, where we talked about dose range checking. We have a calculation of doses based on weight and body surface area. And we put some significant restrictions on that recommendation based on what is feasible and manageable. This recommendation says, "The system shall provide medication dosing decision support that detects a drug dose that falls outside the minimum-maximum range based on patient's age, weight and maximum recommended adult dose, if known, or maximum recommended pediatric dose, if known, for a single dose of the medication."

I want to lead off the discussion with my experience. We looked at 13,000 dose range alerts that we billed for Hopkins in a previous EHR version. So, we built 13,000 rules. It was table driven. And we looked at how these recommendations were followed. I think that paper might have been in the materials that we sent. If not, I will send it to ONC so it can be distributed to the group. The bottom line is, for the most part, the minimum recommendations were completely not useful. So, minimum dose recommendations, we built them because our pharmacist insisted on them for antimicrobials. And it turns out that they created an enormous amount of noise.

They – especially erythromycin, as an example, erythromycin has a minimum dosing range if you use it as an antibiotic. But if you use it as a motility drug, your minimum recommendation range is much lower. And so, it generated noise based on the antibiotic recommendation. We also found that letting providers know that there is no dose recommendation – and we have that here, "if known" – is

completely useless. This just creates noise. So, we learned from this if we don't have any dose range recommendation, we should be quiet about it. So, those were take-home messages on my end. So, I want to open this discussion and ask you what limitations we want to put on his recommendation if any. I think we probably want to consider similar limitations as we did on the dose calculation we did on item two.

Susan Kressly – Kressly Pediatrics – Public Member
So, I will just tell you, as my vendor has, I don't want to make clinical decisions for my users about what that is. I don't feel like that's in our domain to decide what those high-dose alerts are. We don't have a team of informatics clinicians to make that decision for our users. What I do think needs to happen is that we need to be able to give the user access to best practices or standards as they are writing a prescription. And whether it's FTB or somebody who has that and bring it back and displays it to you, if available, or there is a hyperlink at your medication level where the user can go and look.

We are creating again, I think, a patient safety issue in that hospital systems and implementations generally have people with pharmacists who decide that for them. Those of us in the ambulatory space don't have that, and we don't try to make those clinical recommendations as EHR vendors for our users. We like to pass through information when we have it. And I think that's where we should target. I think minimums is not even worth talking about. My two cents.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Let me parse through what you just said, Sue. So, you say that you would – in your situation, you would rely on third-party resources like – you brought up FTB. There are other databases that have similar information. So, you would refer to implement resources in the EHR that come from people that aggregate and distribute knowledge in that domain. And that you recommend the integration into the EHR of these resources. Did I hear you right or did I fall –?

Susan Kressly – Kressly Pediatrics – Public Member
Yes. And with the clarity of where that data – that information is coming from. So, again, the clinician can decide. The user can decide how reliable that information is and whether they want to follow it or not. That's what I think is right for the ambulatory space.

Albert Taylor – Office of the National Coordinator - SME
This is Al. This discussion aligns perfectly with the recommendations within the NCPDP scrip standard. When they talk about dose ranges, there is a specific note that addresses dose range recommendations. And they specifically say, you know, "NCPDP is not going to be the decider. And so, we're not going to put that functionality within the prescribing standard." And that third-party, it should come from maybe a pharmacology – pharmaceutical companies. It could come from like a Harriet Lane resource. For example, wouldn't that be cool if that was digitized into the EHR and you can say, "The Harriet Lane recommendation is this for this drug for this kid"? Those sorts of things. So, a third-party is exactly aligned with what the recommendations are from NCPDP.

[Crosstalk]

Susan Kressly – Kressly Pediatrics – Public Member
Or even Lexicomp or others. There's a bunch of them, right? It's just – I think you need to tell what the source is and give them the source so they can make a smart decision.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Right. I would just like to point out to another resource. AHRQ funded a research project that actually involved the authors of Harriet Lane. It was called "Step Stools" and it created the database of dosing recommendation for pediatric drugs. Subsequent work that was sponsored has updated that database. So, this is another open, available, free open resource that the U.S. government created. So, I think – that's – you know, I'm happy to get you in to – get ONC the connection to the people that are still working on this.

Albert Taylor – Office of the National Coordinator - SME
And who says we are not here to help?

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Excellent.

Chip Hart – PCC – Public Member
This is Chip. I just want to go on record as saying I agree with Sue wholeheartedly. We do not want the EHRs in the clinical decision-making business. We want the clinicians in that business. And the one addition I'd add to wanting to cite your source is that we would also – I would ideally love to have some sort of ability to test a HER's accuracy in this regard. I want to – it's one thing to say, "Hey, look. It works. I'm pointing at the Harriet Lane line-item resource for this potential maximum overdose." But I want to test – I want something that tests to make sure that the EHRs are flawless in this way. This is – we're flying airplanes, and I want every plane to land properly.

Albert Taylor – Office of the National Coordinator - SME
Just a quick follow-up on that and just a question for you. When you think about that testing, do you think that is part of – the certification would test that, or do you think that part of the criteria for certification is that the vendor has a robust QA QI process around this or both?

Chip Hart – PCC – Public Member
Well, I – okay. Fortunately, you gave me both answer, because that is my choice. But if I had to pick one, I would – even though it's annoying, I would rather have it be the testing process. Just because every vendor's view of what a QA QI process varies quite a bit. And at the end of the day, the vendors have to sell their product, and promises get made, and so forth. This is a patient safety issue.

[Crosstalk]

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Go ahead, Sue.

Susan Kressly – Kressly Pediatrics – Public Member
Well, I would just also say that this – wherever we can figure out how to put usability into this, right? Having the website there on the script that I then have to copy and paste into a URL to get there is not meeting the spirit of what we are talking about, right? And people hate extra work. And some external places lockdown your access to get to an Internet-accessible place, right? So, it would have to be able to be demonstrated that is useful and usable by the end user.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair

Thank you. As an end user, I just wanted to add that I agree with Chip's selection. I would want to see in the certification process a medication being ordered, a medication being dosed, and if outside the range, an alert is fired. And then being able to show that this alert is congruent with whatever data source is being used to create the alert. I would want to see it from ordering to the alert and show the work as well.

Steve Waldren – American Academy of Family Physicians – Public Member
Yeah. This is Steve Waldren. I think getting both makes the most sense because you can't test everything in certification. And they need to have a process to be able to identify and solve problems. The one thing about the usability – while I completely agree that we need very usable systems and usability is a really big problem, I have a real concern though of using certification as the forcing mechanism for usability. I think if there is some process of user-centered design and those types of things, maybe. But just trying to mandate usability, I think, is problematic.

Susan Kressly – Kressly Pediatrics – Public Member
No, I agree with that. But clearly, there are some of the certifications that say that you have to demonstrate you used a user-centered design or feedback from your end users when you did this, right? And so, at least inserting the end user or UX designer in the process and being able to document that you did that is – at least we didn't wait until the last two seconds and code around this. And it gets rolled out and everybody says, "This is useless" kind of thing.

Steve Waldren – American Academy of Family Physicians – Public Member
Right.

Chip Hart – PCC – Public Member
Yeah. And Steve, I would just add that I agree with you entirely except that the alternative right now is that we are using the market to determine usability. And that's clearly failed. So, there's got to be some other method. And I think you're right. Mandating UI is like crazy. It's like mandating the weather. But right now, we have too many examples of it not being focused on it all, and that's why we are here.

Steve Waldren – American Academy of Family Physicians – Public Member
It would probably be more than the ten-minute conversation we have left, but I agree that the market has failed.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
So, this is Lauren. This may be a good time just to take a quick break for public comment, since we are right at the 10:20 mark if that's okay?

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Please. Thank you very much for keeping us on schedule.

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

Operator

Yes. If you would like to make a public comment please press *1 on your telephone keypad and 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 the star keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thank you. Do we have anyone calling into the queue at this time?

Operator
Not at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. All right. Well, I will turn it back to the co-chairs. I think we can probably utilize the last nine or 10 minutes or so before we adjourn.

Carolyn Petersen – Individual – Co-Chair
Sounds good.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Alright. Carolyn, do you have anything that you want to bring in at this time? If not, I think we will turn the discussion back to this recommendation or at least try to sum up what we heard today.

Carolyn Petersen – Individual – Co-Chair
No. I think it's great to go forward with the sixth recommendation and keep going on that. It's a really good discussion. It seems that we're really clarifying ideas and kind of narrowing what we want to say with regard to the list.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. So, I think we've reached a rather remarkable quick consensus on this. None of us wants to see the vendors being the source of dosing recommendations. But there was consensus that there are existing sources for dose range recommendations that should be integrated into the workflow process in the EHR and that the certification should focus on walking through a medication dosing, and the medication does recommendation process, and demonstrating that the right information based on the information source being used reaches the pediatrician, and that there's also an element of show your work that the EHR lets the pediatrician identify where the recommendation came from.

Chip Hart – PCC – Public Member
That sounds great.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. Okay, good.

Susan Kressly – Kressly Pediatrics – Public Member
Love it.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair

Wonderful. Well, that's you all's work. I'm just echoing it back. Wonderful. That means we are mostly done with this, except to ask Al if there's anything that he wants to and in the form of the application program interface or the core data interoperability issues. I think at this point, they kind of not necessarily seems to be required at that point, right? Maybe we lost Al?

Albert Taylor – Office of the National Coordinator - SME
I'm sorry I was on mute. But yes, I agree. There's nothing really to add on this right now.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Okay. All right. So, I'm not quite sure if it makes sense to go on to recommendation seven. What do our ONC friends think?

Albert Taylor – Office of the National Coordinator - SME
I think that we won't be able to finish.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
So, then I would say that we –

Albert Taylor – Office of the National Coordinator - SME
I don't think we'll be able to finish in five minutes or six minutes – now five minutes. So, I think keeping the trains running on time and giving somebody back five minutes of their life would be more valuable than trying to weigh into recommendation seven.

Susan Kressly – Kressly Pediatrics – Public Member
Thank you.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yeah. Thank you very much. And unless there any objections, I will turn it over to Carolyn for comments. And then I will give us – we can move on.

Carolyn Petersen – Individual – Co-Chair
Well, thanks, Chris. From my perspective, the discussions that we've had today are exactly the kind of thing that the HITAC will find informative and helpful as we go forward with our work. And I'm really pleased to see how well things are jelling and how well the workgroup is working together. Please, let's continue these good discussions next Friday.

Chris Lehmann – Vanderbilt University Medical Center – Co-Chair
Yay, us. Thank you very much.

Susan Kressly – Kressly Pediatrics – Public Member
Goodbye, have a good weekend.

Beth Myers – Office of the National Coordinator- SME
Thank you, everyone.

Steve Waldren – American Academy of Family Physicians – Public Member
Take care.

Beth Myers – Office of the National Coordinator- SME
Bye-bye.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Bye-bye.

[Crosstalk]

[End of Audio]

Duration: 85 minutes