NATIONAL QUALITY FORUM

Moderator: Interoperability Project
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Operator: This is Conference #83005979.

Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please stand by.

Jason Goldwater: Good afternoon, everyone. This is Jason Goldwater from the National Quality Forum, and I want to welcome everyone to our final webinar on the Interoperability Project. We thank you all for taking time out this afternoon.

The purpose behind this webinar is to go over the comments that were received between – in the month of June with respect to the Interoperability Measure Framework and to get consensus on behalf of our committee as to how we should respond to those comments and how we need to address them within the report.

I do want to remind everyone, this is our final webinar. There will be no meetings after today. We will not be having any follow-up e-mail discussions or be able to arrange an ad hoc call as the project will close at the end of August. So we do need to get through the comments today and make sure that we have the committee's thoughts and opinions on how they would like to respond to them and how we need to change the framework if we need to change it in order to accommodate the comments that were received.

The way we went about this is there were 113 comments received during the month of June. We went through with all of the comments and those that were similar or had similar themes, we grouped together and put it in a post

comment memo, which we did sent to you all. In addition, we did send the Excel spreadsheet that did have every comment that was received. But the ones that were on the post comment or the ones that were mentioned the most often by large majority of commenters and even though a couple of these are issues that we have dealt with in past webinars, given the preponderance of the comments, we have to go over it again to make sure that the committee is able to validate their initial decision or if there are changes that you would like to make based upon the comments that were received.

Again, I do want to stress, this is the last webinar that we're having, so we do need to get through the entire memo and make sure next here we have committee consensus on all of the comments so we would ask the committee members when they are responding to try to keep their comments brief and concise, and that we try to reach consensus as possible.

We're going to turn the meeting over to Mark Savage or Rainu Kaushal, our two co-chairs, and they will lead you the rest of the way. Mark and Rainu?

Mark Savage: Greetings, everybody. (Inaudible) at the moment is that I'm sad this is going to be our last meeting. Jason, you did a great job of summarizing everything and the materials that we got. Rainu, did you have anything you wanted to say by way of introduction?

Rainu Kaushal: Sure. So welcome, everyone. I've been impressed to how effectively and rapidly we've come to where we're at with this set of activities, and I look forward to the next two hours in reviewing all of the comments. And with that, may be we can turn it over for a roll call.

(Carol): OK, sure. This is Carol from the NQF staff team. So I would just go through the committee. Julia Adler-Milstein?

JohnMarc Alban?

A. John Blair?

A. John Blair: Here.

(Carol): Thank you. Chris Boone?

Jason Buckner?

Hans?

Kimberly Chaundy?

Sarah Dinwiddie?

Mark Frisse?

David Hirschorn?

David Hirschorn: Here.

(Carol): Thank you. David Kaelber?

Terry Ketchersid?

Terrence O'Malley?

Frank Opelka?

Frank Opelka: Here.

(Carol): William Rich?

Robert Rosati?

Robert Rosati: I'm here.

(Carol): Robert Rudin?

Theresa Settergren?

Theresa Settergren: Here.

(Carol): Thank you. Jason Shapiro?

Bruce Sigsbee?

Jason Shapiro: Sorry, Jason Shapiro here. I was on mute.

(Carol): OK. Thank you. Bruce Sigsbee?

Alan Swenson?

Alan Swenson: Here.

(Carol): Steven Waldren?

Steven Waldren: Here.

(Carol): Mariann Yeager?

OK. Is there anyone who may have just joined who is on the committee that haven't announced themselves?

Jason Buckner: Yes. This is Jason Buckner.

(Carol): All right. Thank you, Jason. Anyone else?

OK, all right. Well, I'll pass it back to you, Mark and Rainu.

Mark Savage: Thanks so much. So maybe it would be a good idea to follow the layout of the briefing memo that we all got and go through with the themes, make sure we cover all of that, and then check to make sure that if there's anything that anybody wants to raise that hasn't been covered by the themes, we'll make sure that we cover that as well at the end, but the themes do nicely pull together a lot of the comments (at least in) my own review.

Does that sound good to folks on the phone?

Male: Sure.

Female: Yes.

Female: Yes.

Male: Yes.

Mark Savage: OK. So the first comment was on the definition of interoperability, the suggestion that we needed to explicitly focus on the 21st Century Cures definition. And indeed it looks like that, that's a staff recommendation for the proposed committee response. I don't know that it seems that the Cures definition indeed was built on the roadmap definition. I understand that …

(Crosstalk)

(Off-Mic)

Mark Savage: Can somebody go on mute, please? That the 21st Century Cures definition did build on the roadmap. So it's – they seem quite consistent, but I understand the recommendation to have a single definition.

(Jason), (Harold), (do have anything) to add on that recommendation from staff?

(Jason): No, none from us.

Mark Savage: Rainu, did you have anything you wanted to add?

Rainu Kaushal: No. I think that makes sense and – no.

Mark Savage: OK. So any committee members have – what do you think of that recommendation? Any disagreement?

Female: No disagreement from me.

Steven Waldren: This is Steven Waldren. So that the committee wants to go that route, I'm comfortable with that. But I do think there's – there are two things. So, one, you know, in the 21st Century Cures definition, you know, (sub-item C) that talks about does not constitute information blocking as defined by another section in the statute. It's just a reiteration of (A and B). My concern really though is with the Part B, which is the add-on piece to the roadmap definition,

which allows – which says, allows for complete access, exchange and use of all electronically accessible health information for authorized use under law.

So – and I think if we want use this definition, then I think we have to understand that what we're saying is that all current EHRs and health I.T. is not interoperable by that definition because they are not able to provide the complete access to all electronically accessible information. So I'm little hesitant to say that much, so we want to take the interoperability definition (out) and say, the gold standard definition for interoperability is an endpoint to 21st Century Cure piece.

Mark Savage: Any other comments?

Rainu Kaushal: Hi. This is Rainu. I think that, that's an interesting comment. And I would actually agree with that because I like the idea of referencing a gold standard definition but not holding ourselves to a level of accountability that nobody would qualify for it in the country.

(Off-Mic)

Frank Opelka: Yes. This is Frank. So I also agree with that comment. I mean there's true interoperability and then there's working interoperability. And if we were to achieve either one of those, it would be a step forward form where we are. So the 21st Century Cures is more true interoperability. And just to get to a level of working interoperability is the certain level of success we don't currently enjoy.

Mark Savage: Jason, would that be consistent with the recommendation we can indicate sort of a gold standard and the working standard?

Jason Goldwater: Yes. I think that's fine. I think in the context of the report, we'll stick with the definition we have and say, you know, we're striving for the gold standard definition as outlined in 21st Century Cures, which is – and then what that definition is. And that can also be the response to the multiple comments on this particular issue.

Mark Savage: Great. Anything further on the Theme 1? Thanks so much, Steve, for the comment and (pulling) that out.

Theme 2, Interoperability Sensitive Measures, something that we …

Hans Buitendijk: This is Hans Buitendijk. Can I – I was not able to speak due to technical challenge here. I just had to redial in. Not sure where it ended up, but regarding the first theme, the one part, the comment that I want to mention, I like – I'm OK with it being tied to the 21st Century Cures in general.

But the third part just not (constitute with the) information working would create other problems as well even as a gold standard, that where interoperability occurs. But it's not necessary yet using standards because the standards have not been identified, agreed to, but it contributes towards whole exchange – data of all exchange or more exchange. That's still would be considered interoperability, but by way of this definition it would not. And I think before we get to everything being fully standardized, that's a long way coming.

So, I could work with the first two, but the third one is for a number of reasons; very problematic to include as a definition of interoperability. Just wanted to add that before you move on given the technical difficulty I had.

Mark Savage: Thanks so much, Hans. Do you think – the way Jason articulated was, we would continue building with the existing definition and the report and note the gold standard. Is that …

Hans Buitendijk: That's fair.

(Crosstalk)

Hans Buitendijk: That's fair and reasonable. (We can start it moving).

Mark Savage: OK, very good. So moving to the second theme, Interoperability-Sensitive Measures. Anybody have any comments on that theme and what they thought about the various comments?

Rainu Kaushal: And I – this is Rainu. I think the concern was, was that the examples and the definition of interoperability-sensitive measures felt somewhat ambiguous. We got something we've struggled a lot with as a group, and it's – I think it's probably an inaccurate comment. I just don't know how we want to respond to it.

Steven Waldren: So, this is Steve. The things that I thought about, too, is I think about, you know, a definition for interoperability-sensitive measures that I think of both a principle than a practical definition. Just kind of funny because it starts to build that with the interoperability; the one that we just talked about.

But from a principal definition, I would say that – we could say that it's a measure where the presence of interoperable system is likely to see a better performance than in the absence of interoperable system. And to make that kind of a practical definition, I thought (as) where determination of the numerator for a measure requires the use of data that is produced external to the entity reporting the measure. This data may be acquired by electronic exchange or other methods; therefore the measure is sensitive not dependent on interoperability.

Jason Goldwater: Steve, this is Jason. Do you want a (job)? Can you just repeat that, so we can capture it?

Steven Waldren: Sure. And I also can send it to the interoperability e-mail box but …

Jason Goldwater: That would – actually, that would be perfect. Thanks.

Steven Waldren: All right, I'll do that.

Hans Buitendijk: I would support that direction to clarify more what sensitive means. That's helpful.

Mark Savage: So this is Mark. The one thought I had, sort of building on what Rainu said, we certainly wrestle with this a lot. And I ended up being comfortable with the, I don't know if I would call it ambiguity, but comfortable with the lack precision because we are also providing guidelines to measure developers. We're actually trying to provide a framework and (use) some of the more

practical and detailed developments to folks working in the field. So, I was – personally, I was fine with not getting into any further detail myself. But don't mind getting into further detail.

Theresa Settergren: This is Tess. I just wonder if we need actually see that in our final report. If we're going to define a little bit better what interoperability sensitive means and Steve's definition is great. Maybe we need to also say that further work will be done by the measure developers to refine the ultimate measures or something like that.

Mark Savage: Any other comments from committee members? Good. Do other committee members like the idea of being a little more specific along the lines of what Steve was suggesting?

Female: Yes. So, I think that's a good idea.

Male: Agree.

Male: Right, I'm OK.

Female: Agree.

Male: I agree.

Male: And I agree.

Mark Savage: So, Jason, do you have what you need to work with on that one?

Jason Goldwater: We do and thank you all very much.

Mark Savage: OK. Moving on to the third theme, expanding beyond the focus of the EHR, which I'm interested to know what other people saw on the comments. I sort of found two different threads, so I would lift them up separately. One was that more around the report being about exchange with through around EHRs but then there was a – there was a separate set of comments we talk about that seem to focus more on the other things outside of EHRs like wearables, devices, mobile devices, and things like that.

So, any committee members have comments on this third theme?

Rainu Kaushal: (Hey), and I think there was another theme in there which was the – it seems to be like there was clinical interoperability. Yes, it was clinical interoperability that expanded beyond EHRs to wearables and devices. And then it felt to me like there was research interoperability. And I don't know if I'm reading that right, but that was my sense of it. I do think that research interoperability is beyond the scope of this. And I think that clinical interoperability today is very much focused on the EHR world, but we can acknowledge that future work particularly as the fields evolve around medical devices and wearables would be warranted. But – so that was my sense to this one.

Theresa Settergren: This is Tess. If I could just comment on the research interoperability. You know, for an academic medical center, the ability to extract interoperable data from our electronic health record as well as

(Off-Mic)

Theresa Settergren: … devices and wearables …

(Crosstalk)

Theresa Settergren: I'm sorry.

Mark Savage: You no longer interoperates.

Theresa Settergren: Right, right. And so we're grappling with that at Cedars-Sinai now. And so, I totally agree that we at least need to acknowledge the importance of interoperability between the electronic health record and research databases. I just want to call out that, you know, if we're ever going to transform health, we need the research and we need to use the EHR data to support it.

Frank Opelka: So, this is Frank. Yes, I want to pile on. I don't think this is about EHRs. I think it's about patients and their digital information. EHRs are just one source of digital information and only one source. And there many more – and there are many, many more coming. And if we're going to say to the

Federal Government, they're asking us, how should we interoperate EHR data, fine. But if they want to interoperate data on behalf of patients, its research, its smart phone, its iPad, its patient cloud, its EHRs, that's where (applications) find the digital information they need to better their health care.

Hans Buitendijk: I agree. And I would (sort of buy) along to that, that typically – and we could clarify it more, when there's talk about EHRs that typically excludes a lab systems, radiology systems, imaging systems, other PHRs, other kind of systems that gather and collect data, still part of treatment or otherwise. EHR is a very narrow slice of the HIT pie.

And what I can see is that with some of the measures, we may want to encourage to focus more on some of the typical EHR to EHR, EHR to LIS, et cetera. None of these other ones should over time or (conceptually) be excluded because they all contribute to creating a full picture of either the patients complete record in some way. Or that they contribute to advancing the knowledge that we can use to further improve treatment that had subsequent point in time. So I think they are all valid, fair game, and that we should not preclude that. And interoperability happens across all and can enhance all of them.

Mark Savage: So this is Mark. I thought that the combination of the texts of the draft report, which really does describe this large landscape with the actual Appendix A, which there are occasional references, DHRs, that is generally much – is not limited to EHRs; did a good job of creating a framework that would capture that. That was my own thought.

Steven Waldren: Yes. So this is Steve. I agree with all the comments and I agree with you, Mark. But I think the language and the section on interoperability is more than EHR to EHR, starting on page 7. It does that but maybe what we want to do is kind of that first sentence. It does say the emphasis of interoperability is moving data from one EHR system to another.

So we kind to (strike) the whole section by counteracting what we named the section. So maybe it's something (like) – although the current emphasis on interoperability is that it must be more than that and then you can keep going

in that paragraph talking about the EHR interoperability but then you have the second paragraph. We may have to change the however, but change that and then that whole second paragraph talks about it's more than that.

So I will support what's been discussed in regards to change. But I was trying to be a little more concrete.

Mark Savage: Thanks, Steve.

(Karen Alder): Is there anyway – this is (Karen Alder), and I kind of agree with Frank. I'd like to pile on to what Frank had mentioned that it's about the patient. Interoperability is about the patient. It's for the patient's benefit, for the patient outcome.

And then back to Tessa's comment about if we're going to make a difference in health care, and the shift need to be away from EHR like we were only thinking about EHR to EHR. It needs to be more about patient's outcomes.

So is there a way to refine that opening statement when we're talking about interoperability, that we're talking about, you know, as Frank so eloquently put it, it's about the patients and their data. And every – you know, and that includes claims data and electronic health record data, and laboratories and medication management system, and, you know, clinical notes from a physician's office, and, you know, could possibly down the road, you know, IOT and other, you know, sleep apnea and other devices, and on and on and on.

Rainu Kaushal: I'm sorry …

(Karen Alder): (Can we not) …

(Crosstalk)

Rainu Kaushal: I'm sorry, who is this speaking?

(Karen Alder): My name is (Karen Alder).

Rainu Kaushal: I'm sorry, we do actually – I'm assuming that you're member of the public. We do like to keep the conversation between the committee. And we do have a time set aside for committee comments. Thank you for your insight – I'm sorry public comment. Thank you for insightful comments, but we do want to keep this limited to committee discussion since we are little limited on time.

Mark, I will send it back to you.

Mark Savage: OK. So one of the ways that language has been used to sort of capture some of that, what Frank was saying, is sort of patient at the center. And I'm wondering if we perhaps have the ideas here in these paragraphs but we can – we have some of the sentences more around the patient being at the center of this activity, the importance of that data. That sort of explains why we're bringing in the different sources of exchange and information. And maybe even just looking at the diagram, the figure one instead of having electronic health data exchange it to center, you could say patient, put the patient at the center of that diagram and maybe that helps people conceptualize.

(Karen Alder): That would be awesome.

Mark Savage: Not a problem. And let me correct myself, patient and person because it's not just people with conditions.

Male: Got it.

Rainu Kaushal: Yes. Why not just do person?

Mark Savage: Sure. OK. Do we need any further discussion about the research points? Jason, I know precision medicine initiative is actually trying to build in connections with research right now. It seems like the framework would embrace that possibility. Is that – do we need any further discussion about that?

Jason Goldwater: I don't think so. I think we have enough here where we can rephrase that guiding principle to accommodate the comments of the committee, where we would certainly mention the patient being the focus and difference aspects of

interoperability as well as the different device, you know, different data sources that contribute.

Mark Savage: OK. Any further comments from committee members about Theme 3?

Moving right along to Theme 4, Role of Privacy and Security. And I think they are the – one of the larger suggestions was that private and security needed to be its own sub-domain. Any committee members have comments?

Theresa Settergren: This is Tess. So, I'm sorry, I'm jumping in; maybe somebody else was jumping in, too. But I understand where the readers were coming from. I'm just not – I'm not seeing how this would contribute to measures of interoperability, the comment that I would make.

Rainu Kaushal: And this is Rainu. Just to add on that. I see – and maybe we're also looking at the comments on data blocking as well where when data blocking was included, the suggestion was – where we included data blocking, the suggestion was to take that out because it wasn't that relevant to interoperability.

Steven Waldren: So – this is Steve …

(Crosstalk)

Hans Buitendijk: There is part of it that humps, that strikes me as being potential of interest here that measures perhaps could be built around, and that is around access and query that exchange some of this role, but (particularly) other ones where questions of adherence to consent requirement past by the patient or otherwise. So, it's going – not as much into the – it is more on the volume and the behavior of the data than some of the impact. And the impacts could be addressed as well based with some privacy security; are we impacting that because of the absence of appropriate adherence to or ability to convey the privacy characteristics of the data and therefore data is disclosed that should not have.

So I can see an angle there. I'm not sure whether it's among the framework. One of the main ones that we would be mostly concerned about, but I can see the concern that we may want to recognize that.

A. John Blair: You know, this is John Blair, and I would agree that it should be a theme. I don't think we should underestimate the critically of a trust framework, particularly when you want this to scale nationally. Not just with query but even with push, if you don't have the – if the privacy and security is not addressed, cleared down the endpoint on who is sending and who is receiving, I think that's a dramatic effect on interoperability.

Steven Waldren: This is Steve. So – well, first, a pet peeve. It's confidentiality and security, I think, not privacy, but (I won't die in that sword). But I wonder about though adding one principle around confidentiality and security, and privacy, and the fact that the interoperability needs to balance that availability to support privacy confidentiality and security because I think that goes across, you know, the entire realm of the interoperability. If we think that there needs to be some point to a sub-domain, I could see us having something about, you know, appropriateness of exchange under the domain of exchange of electronic health information.

(Crosstalk)

Male: … to put that under the first domain.

Mark Savage: So this is Mark. My own thought was that privacy and security are important just as interoperability is important. But it's – and there is some overlap, but I didn't see a need to list it up in this measurement framework. It felt like, sort of like the – a little bit more (attenuated) even on the interoperability-sensitive discussion that we had. It was pretty hard to figure out how some of these things fit into an interoperability framework itself.

Rainu Kaushal: Thank you for saying it better than I did, Mark.

Mark Savage: Anybody else have comment to share? So where are we on the notion of whether it's something needs to be – whether the framework we've got now is

sufficient on this or whether some things needs to be added. You need general sense from folks on the phone?

Jason Goldwater: (We have a) split; some believe that it would be helpful and some believe that it's not needed.

(Vishali): This is (Vishali) and I don't want to insert myself too much here, but given that there's a split, just wanted to mention that, you know, there were number of federal partners who had suggested that this was a gap in the framework. And, you know, I think as John Blair noted privacy and security having that in place is certainly an underpinning, you know, with regard to trust.

So it may be that it needs to be addressed in some way. But I think it might be – because there's – you know, within the document itself, I'm not – it may – I don't even know if it's mentioned at all. And if it is, you know, may be just in passing. So, you know, it's something that probably needs to be addressed in some way. And, you know, from our perspective, but, you know, leave it up to the committee as to how it should be addressed, so.

Hans Buitendijk: Let me add.

(Crosstalk)

Mark Savage: Go ahead, Hans.

Hans Buitendijk: Maybe a suggestion that adjusting a little bit what Steve (firm), the area wasn't really focusing on that at. Under availability of electronic health information, I think there were – we had (inaudible) in that space two things. One is that we could consider including some text to further clarify as part of availability that privacy and security comes into play, that consent is important to understand what can and cannot be made available, and do something under that header or have a separate header which would put more emphasis on it, still in the exchange of electronic health information area. But we might start, and it maybe sufficient to have one or two sentences under availability of electronic health information.

A. John Blair: Yes, this is John again. I mean consent being in there is OK, but you don't have to have it for certain kinds of interoperability. So I don't want to infer the hinges on that. I think, though, that without addressing the trust infrastructure in terms of privacy and security, you can't scale on a national level interoperability.

So, you know, if we're talking about national interoperability, I mean it can happen without a trust framework which requires privacy and security be addressed, particularly at patient identification level. I mean I may not – provider or patient, whatever the end user is, that has to be dealt with.

Mark Savage: So building on what (Vishali) and Hans said, I did a quick search in privacy and security, or privacy – and actually (I looked) for trust, but it's not really discussed. So I think that may be a great approach to include some sentences about the importance of – about the intersection between trust framework and interoperability (if they're released), yes.

Jason Goldwater: This is Jason. So we can certainly do that under the sub-domain of availability of electronic health information that's satisfactory to the committee. The measure concepts will go under that.

(Vishali): It could also – this is (Vishali). It could also be included, you know, potentially under the methods of exchange that, you know, that having, you know, that infrastructure in place, the trust framework in place is, you know, I would say, it's part of the methods. You know, that might be another place potentially where you could include some language.

(Crosstalk)

Hans Buitendijk: And maybe the part is that the confidentiality privacy parts fits more under availability. And the security, the encryption, the trust framework, the rules fit more under the method of exchange and that …

(Crosstalk)

Hans Buitendijk: … as we look at it.

Mark Savage: Yes, (absolutely).

(Crosstalk)

A. John Blair: And that's fine.

(Vishali): Yes.

(Crosstalk)

Theresa Settergren: That sounds like a great (approach).

Frank Opelka: This is Frank. So just agreeing with what Hans is saying, I also say, I'm also listening with conversation thinking that as the trust networks emerge and there is still a lot of work that needs to be done here, future work in measurement is going to need to evaluate the effectiveness of the trust network. So we don't have measurement systems today that per se will do it. We can get to a working (upper) interoperability in the trust framework by getting through interoperability, and a trust network is yet to arrive. And it's going to be future work.

Mark Savage: So the folks on the phone, I think, we've got sufficient closure here?

Male: Yes.

Female: Yes.

Female: Yes.

Male: Yes, I'm fine, I'm fine.

Mark Savage: OK.

Male: Yes.

Mark Savage: Thanks so much for the comments. Moving on to Theme 5, Data Blocking. A continuing conversation as Jason mentioned at the outset.

Any comments from folks? Anybody – I think that we need to treat this anyway other than what we've concluded after a long, long, long discussion.

Steven Waldren: This is Steve. I don't think so, but I think if we wanted to give a little bit more (image) to data blocking that as you're revising the availability piece that there could be a discussion of, you know, data blocking and that availability, you know, shouldn't have the data blocking piece to it. So I could see Jason and the team beefing that up just a little bit. But I'm comfortable with not changing what we've done to.

Rainu Kaushal: Yes, I'm also comfortable with not changing what we've done.

Hans Buitendijk: This is Hans. I would agree that we have to be careful there. There's a one point that is around the information blocking that given the definition in 21st Century Cures, that it's not only about blocking availability of data inappropriately due to "I just don't want to give it" versus privacy considerations. It also includes statements about non-standard use of interoperability. And that's for me the more concerning part. That's – and I am not sure that we really want to get into it here too much. But that's the concerning part is that having data available but not yet in a standard format because there is no standard or there are too many different standards. So there's no consensus yet. Those can takeaway from already being moved well on the way of availability.

So that's why I'm very concerned with getting too far into information blocking in this context because it opens all kinds of cans of worms in that area. So I'm comfortable keeping it in the place where it currently sits and not go much further than that.

Mark Savage: So I – this is Mark. I agree. I'm fine with where we are with the framework as it is on information blocking.

David Kaelber: This is David Kaelber cover. Me, too, I like where we are.

Mark Savage: So, Jason, anything further needed from the committee on this theme?

Jason Goldwater: Not at all. We're good.

Mark Savage: OK, moving on to the next theme on use cases. The only thing that I would add to the memo about this is I thought it was sort of an interesting juxtaposition with some of the comments about existing measures, which I thought was one of our efforts to try to illustrate without limiting the work of measure developers down the road. Just – when I read the comments, I sort of had that in mind as well.

Anybody else has thoughts?

Terrence O'Malley: Yes, Mark, Terry O'Malley. You know, I actually thought this was a really significant comment, just sort of the general category, because of one of the challenges that I've had with the interoperability piece is how different it is depending on who the stakeholders are.

And I think it's very easy to get high level and make it, A, difficult to implement and, B, difficult to measure. And I see use cases as a strategy for really making it granular and specific for a particular situation. And I like the idea of sort of compiling a library of high value use cases where we can be much more directive about the measure concepts that would really apply in particular use case.

Mark Savage: So, Terry, does that go to the suggestion that we list that as work that would be helpful, like, around the corner.

Terrence O'Malley: Yes, absolutely.

Mark Savage: Yes.

Terrence O'Malley: Absolutely. Yes, it's – yes, that's a requisite.

Mark Savage: OK.

Steven Waldren: I would support that. This is Steve.

Theresa Settergren: Yes, this is Tess. I also support it.

Mark Savage: And it – actually, it's occurring to me, there may be – I agree about just sort of listing it, letting people who commented know that they were heard. We've actually been talking about it ourselves. That there has been some work that was done on that. So I sat on the advanced health models and meaningful use workgroup where we did some work around how to prioritize use cases that were listed in the opening draft of the interoperability roadmap. But it's mentioned that it's something that could be – whenever that next step does come around, it's something that could be looked at to see if it remains useful.

Terrence O'Malley: Yes, and that's – it's Terry again. And that (pulls) in with the – there's another comment on the social determinants of health.

Mark Savage: Right.

(Crosstalk)

Terrence O'Malley: … and that was a comment brought up on the advanced care models and meaning use as well.

(Crosstalk)

Mark Savage: Any other comments on the – on Theme 6 on use cases? Jason, do you have what you need?

Jason Goldwater: We do, thank you.

Mark Savage: Great. Going on to Theme 7 then. Sort of a broad, a broader discussion about domains and sub-domains. Any comments there, especially from people who might've been under workgroups that were focused on usability domain?

Rainu Kaushal: I think it was really helpful what this team did here, trying to create these three different proposals. This was an area that we've discussed a good deal in our first in-person meeting and in our subsequent meeting as well.

(Vishali): So this is (Vishali). I was on the usability group, and originally we had I think a variety of sub-domains within there. And I think – and, Jason, you can correct me if I'm wrong. I think then NQF staff kind of groups those at a higher level because they were – I think they were like maybe, you know, five

or six, you know, in there. You know, like timeliness and, you know, some of these other ones, and they were grouped within the two categories that were in the report relevance and comprehensibility.

That's, I think, in terms of, you know, and what I think some of the suggestions are maybe the, you know, at least, one of them is to break it out a bit more in different ways. So I think that's just the context for me in terms of within the usability group, what had transpired.

Steven Waldren: So this is Steve. I do wonder about adding satisfaction to the current set. So we'd have relevance, comprehensibility, and satisfaction. But I could see relevance deal with effectiveness. And the accessibility, we kind of have that up in one of the other domains of exchange of electronic health information. We talked about kind of availability.

And then if you add satisfaction and you have the ability to talk a little bit about efficiency and potentially, the accessibility by that end user piece of that. So I think adding satisfaction makes sense. The others I could see where they could be shut underneath relevance or comprehensibility.

Hans Buitendijk: This is Hans. Question about that. And so, how would that be different than patient/caregiver experience under impact of interoperability? Would that be satisfaction as well or how do we then distinguish between the two?

Steven Waldren: Yes. Hans, I think you're right. I think it's covered there. So I would pull back my piece. I wasn't thinking about that one, but I think you're right.

(Vishali): So ONC had suggested, this is (Vishali), accessibility as keeping that as a separate domain. It was included within relevance. But, you know, that – in our mind, that relates to clinical work flow and, you know, that's something that we've, you know, based on our survey, measurement work has – that is a major issue in terms of usability as reason cited for not using information that they receive electronically. It's because it's not integrated within their workflow. In our minds, that would be worth calling out separately and is probably distinct from relevance, which kind of relates more to content of the data and whether it's relevant or not. And so, that's the rationale behind proposal number one.

Mark Savage: So this is Mark. I'm looking at the text, and that the text sort of folks says that it's – that timeliness, accessibility, and clinical completeness were intended to be folded in under relevance. So maybe, (Vishali), are you thinking that they don't really fold in that they need to be lifted up …

(Crosstalk)

(Vishali): Yes, that it doesn't – the relevance – I mean, clinical integration and accessibility doesn't really fit in – sorry for the background noise, fit in relevance because relevance – you know, for a measure developer and looking at that. In our minds that, you know, relevance – (click a workflow) a little bit different than, you know, what one would think of, you know, normal person looking at. You know, the word relevance doesn't necessarily – it refers more to the content of the data as opposed to whether the data is – you know, how the data is I guess is presented, is it within your workflow, you know, that kind of thing.

And it's important enough based on the work that we've done, that it might be worth calling out as a separate domain in and of itself because we – you know, in the implementation of any health IT, we know that – you know, if it's integrated within your clinical workflow, it makes a big difference as to whether, you know, it will get used in the usability piece. So, that's the reason for calling it out. But obviously, you know, it's up to you guys as to how you want to keep it as is or, you know, separate it out.

Steven Waldren: This is Steve …

(Crosstalk)

Steven Waldren: Sorry. I think I would be comfortable with adding accessibility. But I think if we do to, I think we also want to call out accessibility from – what I traditionally thought of in usability is for persons with disabilities as well since we're also talking about patients as well as the providers. So, talk about that clinical workflow piece of it, but also for those folks with the type of disability that maybe having access to that information maybe more difficult.

Mark Savage: So I think – this is Mark. I think if we go along those lines, we broaden it beyond just disability since more of a general – like it's general on the provider side. It would be general on the individual side.

Steven Waldren: And, Mark, I'm fine with – this is Steve. I'm fine with that. I was just saying that just workflow is not the only …

(Crosstalk)

(Off-Mic)

Mark Savage: Right. Any other thoughts from committee members?

Theresa Settergren: This is Tess. I just – I sort of agree that while we believe relevance does include accessibility. Probably 80 percent of people reading it, the final document would not make that leap. And so, I would certainly be comfortable adding that.

Mark Savage: Anybody disagree? The people who generally I think we should add accessibility which looks like proposal one.

Rainu Kaushal: I feel comfortable adding it.

Male: That's reasonable.

Male: I agree.

Male: That's OK.

Mark Savage: OK.

Female: Just please …

(Crosstalk)

Jason Goldwater: OK, Mark, we add it. Thanks.

Mark Savage: OK, great. So, anything further on these themes? Sounds like we've got everything, but let me just check.

OK, moving on to the Theme 8, Additional Measure comment. And I think staff noted that there was actually an additional measure comment recommended that didn't make it on to the list which was consumer choice.

(Carol), do you want to say a little more about that, or that's sufficient?

Jason Goldwater: Hi, Mark, it's Jason, yes, that's sufficient.

Mark Savage: OK. OK, OK. So, long – we're not a long list but about the slow under 10 additional measure context, it was suggested here. Do you already have any comment on those suggestions?

Hans Buitendijk: Generally, I have no concerns adding any further examples, measure concepts to clarify. I understand that they're still meant to be exemplar. There are some examples where perhaps we could do better. But I'd like us – the thought that as we get into use cases in the next iteration, not this part of this project, but once that discussion starts, that the number of them will be flashed out. But I have no concerns with getting wherever we have – we use more examples to make it more clear to the reader.

Steven Waldren: This is Steve. I would agree. I think the whole list is fine. I think – I mean some of them I don't know are actual measure concepts, but I have fate in the NQF team to make sure they are by the time to make it for the report.

I would just add an extra plug for the one in the middle about evaluative indicators around work flows. And (redundancies) and burnout, that is a huge problem currently. The provider space I think having an example there would be very helpful.

Mark Savage: This is Mark. For me, I have found many of the suggestions to be sort of more amorphous than what we ended up using for measure concepts. And I didn't know if that was a cause for concern or not. The – because I was reading them, I'm just trying to think how would the reader understand what was being intended. So, I found that a little more difficult.

I did look as well at the last two. I thought that the patient review and use of medical records was already included in what we've got. But I thought the comment about interpretability disparities was a good one. It's something that I've actually raised. It doesn't – it's not really additive to what we've got. Instead it asked to compare across user groups and to help identify where more time needs to be spent or whether there – where there more issues. So, I thought that was a good thing to lift up myself.

Hans Buitendijk: So, I think with a number of these, but I don't think that should disqualify them from being the listed as well. Per earlier comments is that – what are the measures that are going to be suggested and proposed, truly focusing on the interoperability parts or on the system in general regardless of whether the data came from an external source or not. So, for example, evaluative indicators, a number of those, whether you interoperate or not, whether the data is from various sources or not. There are system behaviors that influence that which are not interoperability measures.

What I can see is that each and every one of those from an interoperability perspective may have some interesting measures where interoperability is involved in that. So, I think it's more than general caution that we need to – that we already put around, that may need to emphasize even more, is that these are exemplars and we have to – this framework is meant to focus on the aspect that interoperability brings to the table. Not just general system behaviors regardless of where the data came from. So the line can get very blur.

Rainu Kaushal: So, Hans, I think that relates to this inter – this concept being interoperability sensitive. I'm making sure that …

Hans Buitendijk: Yes.

Rainu Kaushal: … you know, that, you know, in fact these are that, you know, the way it's operationalized is operationalizing the way that sensitives to interoperability.

Hans Buitendijk: Yes.

Mark Savage: Any other comments? So, I think I'm sharing most people have spoken to be fine with including these as examples. Is that a fair summary?

Rainu Kaushal: Yes.

Male: Yes.

Mark Savage: OK. Jason, do we need this to figure where they would fit within the domains and sub-domains? Or is that something that staff can do?

(Off-Mic)

Jason Goldwater: So, we could certainly turn these into measure concepts if the committee believes that through our internal discussions, we'll be able to classify them appropriately, then we can go do that. If you all would like to have a say and where they should go, then we can take on the discussion.

Mark Savage: Do some of the committee think that's important or leave it to the staff?

Rainu Kaushal: I'm comfortable leaving it to the team, to the staff.

Male: I agree.

(Crosstalk)

Mark Savage: This is Mark. I am, too.

Male: OK. We will take that (inaudible).

Mark Savage: Thank you. Any other comments on Theme 8? We're ready to move on the Theme 9?

Theme 9, the Inclusion of Existing Measures and the Meaningful Use and Advancing Care Information Categories. We had comments going both ways, include more and don't include them.

So any comments from committee members?

Male: Agree with both.

Hans Buitendijk: But the challenge with these number of the measures (Big A), MU/ACI, (MIPS) or the ones in the Appendix B is that some of them would depend on further collection of data than what is natively already available through the metadata from the transactions or otherwise. And the more that we get into the need to collect the additional information, the challenge is with how do we go about it and not that there's not necessary value to it, but it becomes more cumbersome. It becomes more interesting for some research rather than national collection by everybody. And I think that's where at least I would have some concerns with expanding too much because there is the risk that we introduce more of those kind of measures and therefore asking for more documentation by everybody.

That would be my concern with including a number of them. But that applies to existing measures in there that are referenced as well. And I think that's more of the – as we get closer to the use case, the actual use case, the actual proposed measure, where we really need carefully look at that and says that, it is fit for purpose for national collection? Or is it fit for purpose for a targeted research endeavor?

Steven Waldren: This is Steve. I would say not to add them. Maybe if we want to talk about changing the labeling on Appendix B to say it's non-exhaustive but I would be against adding anymore of the MU/ACI (measures).

Mark Savage: This is Mark. I thought it was a good balance. The – they were meant to just illustrate and they also feed into the – to our assessment about whether something was short term or long term to show that something was existing, illustrated why we – where we might have come out on that. So, I thought it was the right balance to myself.

Anybody else?

So, we'll leave this one as is? Does that sound like the consensus of the committee?

Rainu Kaushal: Yes.

Male: Yes.

Male: Yes.

Mark Savage: OK.

Male: Yes.

Mark Savage: Moving on to Theme 10 then, which is trying to capture some of the things that seemed worthy but needed to be listed as parking lot items especially at this point in our workflow, with the report coming out around the corner. Any comments on that list? Anything that you'd add or subtract from that list?

Hans Buitendijk: This is Hans. I would add one to the list. It's an extension of use cases into some of the, let's say, Annex B area that given that we have now gone through this one round and we have spent a lot of time on the main body but not a lot of time of that Appendix A and particularly B to review that further. I think parking lot future interoperability work a refresh look at Appendix B examples that you think now benefit that are more sensitive to interoperability would be a helpful exercise to provide more clarity for subsequent efforts. I understand that we cannot do that as part of this round at the effort, but a next round that might be helpful first step to refresh that the couple examples in the comments where ultimate phrasings were suggested that that would be more indicative of interoperability than existing ones.

Mark Savage: Thank you. Any other comments?

Terry Ketchersid: It's Terry. Just a minor request for an addition on the first bullet. So, after acute care, home care, and then I would add specifically home- and community-based services. That's kind of the next frontier and then among others. Push the circle out.

Mark Savage: OK. Any other committee members have thoughts?

So, I'm looking at this, and I'm seeing the last sentence, which I think the answer is, yes, it does. It does make sense to include the section of the final report that list this up. And we've expanded slightly the list of things that we

think would be lifted up, but just to confirm it we like the idea of adding that to this report. Everybody agree on that?

Rainu Kaushal: Yes.

Male: Yes.

Mark Savage: OK. Jason, do the theme have what it needs to – for this piece, this theme?

Jason Goldwater: We do. Thank you very much.

Mark Savage: OK. So, as the – and is there anything further on Theme 10, I should ask?

OK. So as the memo suggested, there were, you know, there were a range of comments. So this is the time also to check to see if there was any particular comment that didn't seem to fall into these 10 themes that somebody wants to list out particularly on this phone call. And if anything we haven't discussed that you think needs mentioning.

I think that sounds like a resounding appreciation for instance, for the theme's ability to reduce all of these comments to 10 themes in a very workable way. Thanks so much to NQF.

Jason Goldwater: It's our pleasure. And we are all giving you virtual high fives for your comments, suggestions, and input; very valuable, will really help us. And thank you for the very specific items.

Mark Savage: Great.

Jason Goldwater: We give you hugs if we were in person but we can't do that.

Mark Savage: OK. Well, we receive hugs gratefully. Thank you.

Jason Goldwater: You're welcome, Mark.

Mark Savage: So should we move to the public comment?

Jason Goldwater: Yes, we should. Operator, could you open the lines for public comment, please?

Operator: OK. At this time, if you would like to make a comment, please press star and then the number one.

And at this time, there are no public comments.

Mark Savage: This is Mark. I do want to lift up that we did hear one comment from, I think, it was (Karen Adler) and appreciated that comment.

And so, (Vanessa), do you want to take us to the next steps?

(Vanessa): Sure. Thank you, everyone, so much for your time and your effort for this committee. We'll take in all your feedback and input from the public comment and incorporate into the final report. Before we do that, we'll first go to copy editing through us internally, and then the final report will be out in September 1st. And I'll hand it back to Poonam.

Poonam Bal: So, yes, basically, we just want to end the call by thanking you for all your hard work. We know you had a lot of webinars knowing – just looking at the slide. And we really appreciate everyone being so attentive and reading all the documents and all the homework assignments. We really wouldn't be able to achieve everything we did without you. So we just want to thank everyone for their hard work. And hopefully, you know, with a lot of these new projects that we suggested we'll get to work with you in the future as well.

Jason Goldwater: And this is Jason. I would certainly echo that and really appreciate everyone working to come to consensus. I know that this is a topic a lot of us have been dealing with for two to three decades. If you get five people in the room and ask what they think about interoperability, you'll get five different answers pretty easily.

So, we appreciate the guidance of both Mark and Rainu as well as their time being co-chairs of this committee and appreciate all of you really working to build towards a consensus framework which we think is really going to benefit the health I.T. community and the quality measurement community, and will be certainly something that will benefit (ONC) as well. So, I echo

Poonam's thoughts. And on behalf of NQF, we thank all of you very much for your service. And we do, truly, hope we get to work with all of you again.

(Crosstalk)

Rainu Kaushal: And this is Rainu. I'd like to knowledge the outstanding staff at NQF as well. You all have made this a much easier and fluid process. So thank you for all your support as well, and direction and guidance and leadership.

(Crosstalk)

Male: Hear, hear, yes.

Male: You're very welcome.

(Crosstalk)

Male: Absolutely.

Female: OK. So …

Female: If we could hug you we would.

Mark Savage: We're accepting those hugs. Thank you.

(Crosstalk)

Jason Goldwater: Hopefully the opportunity will present itself in-person at some point.

Female: So I just want to let you know that our next correspondent you'll hear from us is the final report. We will send you an e-mail letting you know it's ready and posted. And if you have any questions in the meantime just go ahead and e-mail us as you normally would. Thank you. Have a great day.

Male: Thanks a lot.

Male: Thanks, everybody. Thank you.

Male: Thank you so much, everybody.

Male: Sure, thank you.

Male: Thank you. Bye.

END