# CIIC Notes

# January 11, 2018

# Projects

* Need to develop a formal agreement for projects to be part of CIIC
* Russ – Solving the original problem should be added to the success criteria
* Steve B
  + Challenge ourselves to a more agile process
  + Reducing clinician burden
    - Jimmy – that is a derivative of the work. This is the responsibility of the clinical societies to ensure this.
  + Some project owners may have informatics expertise and just need to learn the CIIC way. Some projects will need informatics support. Will need to discuss funding.
    - Julia – people who need a great deal of help may not make it into the first batch of projects
  + Richard E – cancer interoperability has gotten broad engagement for breast, lung, colorectal, prostate. Have 9 specialty societies and a number of federal agencies. Have a principle that they will treat the downstream steps as customers who use the upstream step. They will be building a workflow map that shows where the data is attached to the care process. Will be asking clinicians to review the data models in the context of workflow maps.
    - Susan – Need to have clear guidelines on how to write a use case and how to work clinicians through a domain model.
    - Julia – the group discussed the idea of having a playbook
  + Russ – Marketing did not discuss reducing provider burden, but this should be added to the CIIC messaging. The AMDIS physician IT symposium has dropped IT from its name. Their theme is “moving from caring for computers to caring for patients:
  + Russ – We might want to think of the projects as franchising. CIIC provides certain things and the project has certain responsibilities.
    - Susan – We are going to create a prototype of the FPAR project results in the FHIR sandbox
  + Terrie – this is a knowledge management issues as well as a project issue. There are different level of service that could be to different projects
    - Susan – we need to develop education and guidance so that we have more people who are able to support CIIC projects
  + Keith – Should take a subset of projects that have been successful and elevate their work to recognized national standard. Have presented this idea to groups and they are worried that their projects will be sidelined and that this is too big to be successful. In order be elevated to a national standard should be demonstrated in production systems.
  + Suji – how will projects be selected?
    - Susan – We will have to figure this out.
  + Mark Kramer – did a landscape review of standards. Found 48 standards related to breast cancer. There are already standards out there that are in use. How do you convince someone that the CIIC standards are needed. This might be an issue for marketing group.
    - Julia – We had agreement to use what already exists.
  + Russ – coming with stakeholders in place might be part of the CIIC franchise agreement
  + Mike – in FDA different standards are used by different centers, e.g., CDISC is used by CDER but not by other centers. It is important to contextualize the application of the standards. It is important to understand that complication.
    - Susan – we are in communications with CDISC. They have reached out to CIIC. They are further ahead than CIIC.
  + Jimmy – this discussion reflects the discussion in the breakout session yesterday. There is a need for a resource to tell the participants what is expected
    - GET SLIDE THAT JIMMY SHOWED HERE

## Project Discussion

* Susan – Need to include a description of the problem space for each project
* Julia – Need to have an onboarding process to bring projects into CIIC
* Mike – SHIELD would be amenable to adopting models already developed under CIIC
* Susan – Outcomes are measured in many different ways. Need to understand the structure of outcomes.
* Julia – Additional projects – CATNIP, SPEED
* Stan – NIBDK and National Kidney disease education program contacted Stan. Phenotype and kidney care plan being developed. Need to figure out franchise mechanism to be able to offer to groups like this.
  + Julia – these groups have strong use cases an personas
* Anita – Drug common data elements for different therapeutic areas
* Additional Projects
  + Claude –University of Utah – Define the models and profiles to support opoid app and bilirubin app and patient dashboard
    - Susan – this will require a medication administration model
  + Grant – coding phamaco genetics results, retrieval of patient genomic data and integrating into the HER
    - Susan there is a lot of modeled and coded data for pharmaco-genetic data
  + Richard – Family history data could be a subset of larger models of family history
    - Susan – Should call this risk assessment. Should connect to work that Ken K. is doing.
    - Julia – These are also in scope for the VA KNART project
* Process
  + Julia – We are not ready to select projects
  + Stan – some projects will be well resourced and need CIIC to get their models into a common repository. With funding CIIC could provide advice and consultation.
* Information on projects for onboarding/evaluation criteria
  + See Jimmy’s Notes
* Team characteristics – multi-stakeholder, nationally representative
* Associated stakeholders
* Clinical purpose
* Scope
  + Problem statement
  + Current situation
  + Proposed solution
* Plan for production level implementation
* Existing work that will be built on
* Current standards
* Commitment to use CIIC tooling
* CIMI modeling adoption
* Benefits of the project
* Resources
* Commitment to supporting CIIC
  + Financial
  + In-kind
* Plan for ongoing stewardship
* Testing and validation plan
* Plan for end to end management

Susan – CIIC could provide a list of potential consultants

Mark - Need to have a CIIC training program and require a financial commitment

Russ – Should be cautious about technical language in the agreement

Stan – Models must be open and freely available

Russ – SME expertise should reflect a larger organization or group not just one person

## Franchising Model Approach

Richard – Within the cancer group there are revenue models that license guidelines and risk assessments. Richard spoke to these groups and they agreed that the data models could be free and open and that the logic applied to the data would be proprietary.

?? – Having a common data model around the content would provide value to the content developers.

Rebecca – The PROMIS measures have proprietary testing, but the models are open source.

Richard – If the underlying data is being used by numerous downstream organizations, organizations should be encouraged to have a revenue model that is based on content.

Susan – We will likely pass over models that are proprietary

Stan – LOINC had this issue, e.g., Apgar scores. LOINC has a policy that they will not develop codes if there was going to be charges for the use of the code.

Stan – LOINC is funded by Regenstrief and through membership and grants.

Gary D – Commonality should be a theme – from point of capture through all uses.

Frank O. – think of this starting at the use case. Need to get this into non-technical language

Chuck – need to have a franchise model that is realistic.

Steve ? -- What is the value of being a franchise? Are there different levels of franchises? Need a better name

Steve B – CIIC could offer – community coordination, hosting of models, support for projects, tooling. There will be a start up and maintenance cost to do this.

# Technical Capabilities

Seth – Is there any way to automate these processes to reduce manual effort?

Stan – Would like to do this

Susan – need to do manually to understand the requirements

Keith – Need to be able to search models for duplicates. Need a model guide for nomenclature

Susan – Need a user friendly tool where clinicians can see content. Need collaboration tool for multiple people working across models.

Richard – Cancer group was using spreadsheets and it was slowing them down. Richard has been working on a tool for cancer interoperability.

Siemans – Like the tracking of endorsement and adoption. Want to be able to view the adoption by vendors to assist in planning interactions to upstream and downstream applications.

Stan – the reason for having tools for implementable models is to ensure consistency in the implementation of models. CIIC might not develop tools but would want to be engaged in the development of these tools.

Mark Kramer – Production of standardized FHIR profiles is in the scope of CIMI. CIIC models will be logical models. CIMI has the tooling to develop FHIR profiles.

Steve B – Might have more flexibility for elements that are not core.

Grant – suggested adding a help desk

Richard – How will tooling decisions be made?

* Stan – Could discuss tomorrow
* Richard – Would like people to look at his tool and get feedback and make the tooling available at no cost
* Stan – Would like CIMI to make decisions on tooling
* Virginia – Are there specific tools that CIIC would decide on?
* Richard – CIIC could be a customer and provide input on tooling.
* ??? – Need a picture of the roles in the process of getting to models, e.g., process flow with swim lanes
  + CIIC determines the preferred models
  + CIMI is responsible for
    - Modeling formalism
    - Tooling
    - Translating clinical representations of models to technical representations
* Gary – Artifacts are produced by CIMI. Would CIIC have a different model
  + Stan – CIIC would determine the preferred model
  + Stan – there are technical choices in modeling that clinicians do not need to be engaged with. Decisions on these technical choices would be made by CIMI.
  + Chuck – For the people who want to use the models, the technical discussions are not relevant. We need to be able to explain this in the simplest of terms.
* Mark – CIMI is concerned with standards and CIIC is concerned with the application of those standards in the clinical domain.

# Marketing

Keith – Vendors should be a priority group for marketing CIIC.

??? – Vendors must build the solutions using the models.

Laura – There are creators and consumers – healthcare organizations, clinical societies, and government agencies are creators. Vendors and payers are consumers.

Stan – We should include vendors but the leadership should remain clinicians. Roberto suggested that CIIC could work with the vendors so that their systems would be CIIC compliant

Grant – Add pharma, bio-pharma, bio-techs to the list of target audiences

Richard – Spoke at the value based-summit. Payers are thinking out of the box and could provide funding.

Mark – We can impact the vendors and developers by moving models into FHIR.

Susan – In her nursing group the vendors provide useful information because they are connected to the vendors.

Keith – Need vendors included because they are key stakeholders.

Grant – Stories should speak to outcomes and costs

Gary – Stories about reducing burden and how errors and omissions are reduced.

Keith – Stories about commercial opportunity

Siemans – Providing actionable data with analytics.

Stan – ACS CEO Dr. Hoyt has offered to provide their marketing firm to develop a campaign for CIIC.

Keith – Might market the interoperability concept of which CIIC is a piece.

Stan – Absolutely!

The attendees approved accepting the offer of ACS to provide funding to ACS’ marketing firm to develop a CIIC marketing campaign.

Susan – The nursing group has developed a manuscript template that might be used by CIIC to document stories.

Stan – Who will execute the marketing work.

Anita -- need to identify WG members

Richard – Invited CIIC to speak to the cancer group

Russ – CIIC is presenting at the HL7 Payer summit

Laura – What about changing CIIC name

Stan – Could do a name change in conjunctions with the CIIC HSPC merger

AHRQ – Could do webinar with stakeholder groups.

Virginia will set up a doodle poll for the Marketing Work Group

# Gaining Commitment

See Stan’s notes

# CIIC and Other Organizations

Richard – Would be good to schedule CIIC meetings to follow on the Partners in Interoperability meetings.

Richard/Keith – Discussed concerns about clinical societies wanting to develop models as a revenue stream.

Anita – The Rare Disease Group under NIH is working on standards. Imaging Archiving Group is working with NCI on standards.

Richard – Discussing moving RadLex into SOLOR

# Next Steps

Next Meeting

* Meet 2x per year F2F
  + Julia agree
  + Could do a virtual one day meeting in between F2F. Report on progress and plans.
* Next meeting – June/July
  + Locations
    - FDA
    - ACS
    - CDC
  + HSPC
    - Mid-March New Orleans
    - October – DC/ACS
  + Topic/Focus
    - Report on and plan work
    - Work groups have time for longer discussions
      * Longer time
      * Continue report out discussion sessions
      * Include a tooling group
      * Projects, marketing, tooling, training/documentation
    - Panel to bring in broader perspectives
      * Consider having related groups
    - HSPC merger
    - Marketing company
    - Post agenda ASAP to attract more people
    - Have a pre-meeting with FDA staff working on standards
  + Project support – try out franchise strategy
    - ACOG
    - Pain Assessment
    - Women’s Health CRN
    - CDEs – modeling 15 ONC elements—Registries on FHIR - Seth
    - MD EpiNet RAPID – assessment of interventional devices
    - Imaging – Keith will follow up
    - Cancer Interoperability – Frank
    - ACS logic models for Strong for Surgery – Frank
    - Develop playbook out of the experience of the projects
  + CIIC project support
    - Process for onboarding initiatives into CIIC
    - Elaborate the CIIC “franchise” model into CIIC participation agreement
    - Develop a playbook to support initiatives participating in CIIC
    - Develop education and training program and materials for CIIC participants
    - Develop a repository of projects that can be used to identify opportunities to collaborate on overlapping initiatives
  + Develop requirements for modeling tools
  + Do actual modeling work within CIMI
  + Establish an online model repository
* Collaborations
  + MOU with Sequoia
  + ACC and IHE cardiology – Jimmy, Bruce
  + ACS assist in engaging other societies via David Hoyt
  + SHIELD/NEST – possible MOU with NEST—Mike Waters (National Evaluation System for Healthcare Technology)
  + MD EpiNet
    - Jimmy – FDA is a big driver of data element standardization. May want broader engagement with FDA. NESTcc MDIC (NESTcc and MDIC are the same thing) Medical Device Innovation Consortium
  + AHRQ outcomes measure framework – AAAAI
  + NQRN/PCPI
  + AMA IHMI

# Meeting Assessment

Key messages to communicate out of this meeting

Length

Location

* Suggestions for next meeting

Reception

* Location
* Suggestions

Panel

* Suggestions for future meetings

Breakout Sessions

* Length
* Process
* Suggestions

Other agenda comments

* Suggestions for next meeting

Things to do between meetings

* Wiki content
* Webinars
* Other

Agenda

January 10, 2018

| **Time** | **Topic** | **Presenter** | **Handouts** | **Notes** |
| --- | --- | --- | --- | --- |
| 0830-0900 | Welcome |  |  |  |
| 0900-1000 | CIIC History and Update   * Problem Definition, Value Proposition * Benefits of standardized clinical models realized by Intermountain * Description of the clinical modeling life cycle * Proposal for how groups can engage in the clinical modeling process | Stan Huff, M.D., Chief Medical Informatics Officer, Intermountain Healthcare  [CIIC Introduction SLC 180110.pptx](https://healthservices.atlassian.net/wiki/download/attachments/121995287/CIIC%20Introduction%20SLC%20180110.pptx?version=1&modificationDate=1515603947455&cacheVersion=1&api=v2) |  |  |
| 1000-1030 | Break |  |  |  |
| 1030-1200 | Examples of How to Do the Work  Panel Discussion   * Project descriptions * Overview of the modeling process * Approach to clinician engagement * Lessons learned * Challenges   Projects to be discussed:   * Nursing data standardization * Use of standardized models to achieve interoperability across vendors * Laboratory data standardization and creation of value sets for coded lab tests | Susan Matney, PhD, RNC-OB, FAAN – Senior Medical Informaticist, Intermountain Healthcare  [MatneyCIICSlides\_Final.pptx](https://healthservices.atlassian.net/wiki/download/attachments/121995287/MatneyCIICSlides_Final.pptx?version=1&modificationDate=1515604023993&cacheVersion=1&api=v2)  Ken Kawamoto, MHS, M.D., PhD. – Assistant Professor of Biomedical Informatics at the University of Utah Health Sciences Center  [CIIC 2018-01-10 -- IAPPS approach (for upload).pdf](https://healthservices.atlassian.net/wiki/download/attachments/121995287/CIIC%202018-01-10%20--%20IAPPS%20approach%20(for%20upload).pdf?version=1&modificationDate=1515682188857&cacheVersion=1&api=v2)  Mike Waters – Ph.D. – FDA IVD Real-World Evidence Tactical Team and SHIELD Team Lead  [180110 Waters, SHIELD CIIC Meeting.pdf](https://healthservices.atlassian.net/wiki/download/attachments/121995287/180110%20Waters,%20SHIELD%20CIIC%20Meeting.pdf?version=1&modificationDate=1515604075331&cacheVersion=1&api=v2)  Roberto Rocha, M.D., PhD.  [RRocha - Development and Implementation of Reference Models - Jan 2018.pptx](https://healthservices.atlassian.net/wiki/download/attachments/121995287/RRocha%20-%20Development%20and%20Implementation%20of%20Reference%20Models%20-%20Jan%202018.pptx?version=1&modificationDate=1515604093705&cacheVersion=1&api=v2) |  |  |
| 1200-1300 | Lunch |  |  |  |
| 1300-1330 | Overview of Breakout Groups   * First Projects * Technical Capabilities * Marketing | Virginia Riehl  [CIIC Breakout Group Approach 2018 01 08.pptx](https://healthservices.atlassian.net/wiki/download/attachments/121995287/CIIC%20Breakout%20Group%20Approach%202018%2001%2008.pptx?version=1&modificationDate=1515605922654&cacheVersion=1&api=v2) |  |  |
| 1330-1500 | Breakout Groups - Round 1 | Breakout Facilitators |  |  |
| 1500-1530 | Break |  |  |  |
| 1530-1700 | Breakout Groups - Round 2 | Breakout Facilitators |  |  |
| 1730-1900 | Networking Reception  Bambara  202 South Main St. Salt Lake City, UT, 84101  *Light hors d'oeuvres will be provided.  Drinks will be on your own.* | Reservation under CIIC and Laura Langford |  |  |

January 11, 2018

| **Time** | **Topic** | **Presentor** | **Handout** | **Notes** |
| --- | --- | --- | --- | --- |
| 0830-1030 | First Projects Breakout Group Presentations and Discussion | Susan Matney  Julia Skapik  Jimmy Tcheng | [Project and Process Identification Reportouts.pptx](https://healthservices.atlassian.net/wiki/download/attachments/121995287/Project%20and%20Process%20Identification%20Reportouts.pptx?version=1&modificationDate=1515685861131&cacheVersion=1&api=v2) |  |
| 1030-1100 | Break |  |  |  |
| 1100-1230 | Technical Capabilities Breakout Group Presentation and Discussion | Stan Huff  Steve Bratt |  |  |
| 1230-1330 | Lunch |  |  |  |
| 1330-1430 | Marketing Breakout Group Presentation and Discussion | Russ Leftwich  Anita Walden |  |  |
| 1430-1500 | Break |  |  |  |
| 1500-1700 | Gaining Commitment   * What is commitment * Value proposition for participants organizations * Drivers and barriers * Actions to gain commitment | Stan Huff, M.D., Chief Medical Informatics Officer, Intermountain Healthcare |  |  |

January 12, 2018

| **Time** | **Topic** | **Presenter** | **Handouts** | **Notes** |
| --- | --- | --- | --- | --- |
| 0830-1000 | CIIC Collaboration with Other Groups   * How the work of other groups relates to CIIC * Define opportunities to collaborate * Identify participants who can facilitate collaboration | Stan Huff, M.D., Chief Medical Informatics Officer, Intermountain Healthcare |  |  |
| 1000-1030 | Break |  |  |  |
| 1030-1200 | Plan for Moving Forward   * How will CIIC evolve and become incorporated into medicine? | Stan Huff, M.D., Chief Medical Informatics Officer, Intermountain Healthcare |  |  |
| 1200-1300 | Lunch/Adjourn |  |  |  |

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