Health Information Technology Advisory Committee

Interoperability Standards Priorities Task Force

Meeting Notes – July 31, 2018, 10:00 am – 11:30 am ET

VIRTUAL

The July 31, 2018, meeting of the Interoperability Standards Priorities (ISP) Task Force of the Health IT Advisory Committee (HITAC) was called to order at 10:02 am ET by Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC).

ROLL CALL
ISP Task Force Members participating in the call:
(Member, Representing)
Kensaku Kawamoto, co-chair, University of Utah Health
Steven Lane, co-chair, Sutter Health
Ricky Bloomfield, Member, Apple
Tina Esposito, Member, Advocate Health Care
Tamer Fakhouri, Member, One Medical
Cynthia Fisher, Member, WaterRev, LLC
Valerie Grey, Member, New York eHealth Collaborative
Anil Jain, Member, IBM Watson Health
Edward Juhn, Member, Blue Shield of California
Victor Lee, Member, Clinical Architecture
Leslie Lenert, Member, Medical University of South Carolina
Arien Malec, Member, Change Healthcare
David McCallie, Jr., Member, Cerner
Clement McDonald, Member, National Library of Medicine
Terrence O'Malley, Member, Massachusetts General Hospital
Ming Jack Po, Member, Google
Raj Ratwani, Member, MedStar Health
Ram Sriram, Member, National Institute of Standards and Technology
Sasha TerMaat, Member, Epic
Andrew Truscott, Member, Accenture
Scott Weingarten, Member, Cedars-Sinai Health System

ONC Staff
Brett Andriesen, Standards Advisory Lead (ONC)
Farrah Darbouze, ISP TF Lead (ONC)
Elisabeth Myers, Deputy Director, Office of Policy (ONC)
Lauren Richie, Branch Chief, Coordination, Designated Federal Officer (ONC)
Don Rucker, National Coordinator (ONC)

CALL TO ORDER
Lauren Richie, Designated Federal Officer (ONC), called the meeting to order and proceeded to conduct roll call. She then turned the meeting over to the National Coordinator.

WELCOMING REMARKS
Don Rucker, National Coordinator (ONC) noted that the Centers for Medicare & Medicaid Services (CMS) proposed CY 2019 Physician Fee Schedule includes a blended rate for the clinician office-based evaluation and management codes. This should significantly reduce the administrative burden for clinicians. It will help patients, especially as the 21st Century Cures Act (Cures Act) is making medical notes available to the public. He invited the ISP Task Force (ISP TF) members to submit public comments on the proposed rule. Comments are due by September 10, 2018.

Don Rucker also mentioned that the Second Annual ONC Interoperability Forum will take place August 6-8, 2018. He thanked ISP TF co-chairs **Steven Lane** and **Ken Kawamoto** for their work in getting the word out on the Interoperability Forum. He then turned the meeting over to the co-chairs.

Co-chair Steven Lane, Sutter Health, welcomed and thanked members. He noted the homework assignment, which asked members to review the Interoperability Standards Advisory (ISA) and pointed out that Brett Andriesen, Standards Advisory Lead (ONC) who presented on the ISA at the TF's July 20 meeting, was present to answer questions.

Steven Lane urged members to create a personal account on the ISA site, (healthit.gov/isa). The site also has the Interoperability Proving Ground, which has 410 projects for people in the industry to test standards listed on the ISA. Section six of the ISA includes a number of comments submitted from health IT organizations that members may want to review.

Turning to today's presentation, **Steven Lane** noted that the ISP TF is charged, through section 3003 of the Cures Act, with identifying priority uses for health IT standards adoption. The first priority listed involves priority standards arising from the implementation of incentive programs for certified EHR technology. He introduced Elisabeth Myers, Deputy Director, Office of Policy (ONC) to brief the group on health IT-related incentive payment programs at CMS and how those programs are expected to dovetail with the work of the ISP TF.

Presentation 1 – Supporting the Care Continuum, Quality-Focused Programs & Interoperability
Elisabeth Myers, Deputy Director, Office of Policy (ONC)

Elisabeth Myers was formerly with CMS and while at the agency worked on some of the value-based payment programs.

She referenced Section 3003 of the Cures Act which involves priority use cases that arise from incentive payment programs linked to the use of certified EHR technology. She described the value-based payment programs that will eventually use the priorities and specifications determined from the ISP TF.

The ONC Certification program establishes certification criteria for health IT as a range of individual standards and functions known as certified health IT modules. There are several CMS value-based

payment programs that incentivize the use of certified EHR technology, depending on the provider and what is being accomplished with certified technology.

ONC has created an interactive PDF for better understanding of certified health IT and how it supports clinicians in providing care. The PDF is a user-friendly tool to learn about certification requirements in plain terms. It can be found on the ONC website, Understanding Certified Health IT.

CMS and ONC have worked to ensure that each new program that requires a technological component to support a behavioral action for a program has those technologies available. Even though there are differences in programs, the overarching definition that goes into the packages are aligned to the ONC modules. This was done to give flexibility to providers meeting multiple requirements in multiple programs.

Discussion of CMS EHR incentive-based payment systems

Terry O'Malley, Massachusetts General Hospital, asked if there is a roadmap at CMS to broaden the incentive payment programs to include home healthcare and community-based care providers.

Elisabeth Myers said yes, CMS has made a deliberate effort over time to include more types of providers. Think of the programs that exist today as a floor; CMS is looking at broad use-case standards for multiple care settings. CMS has overarching packages that long-term care facilities are moving toward. CMS wants to ensure that no care settings are left behind.

Clem McDonald, National Library of Medicine, asked whether patients can download home healthcare OASIS data from the CMS Virtual Research Data Center, a Medicare database, using the Blue Button Initiative.

Elisabeth Myers said ONC and CMS are considering working together to broaden the Blue Button initiative. CMS staff would have to follow-up with additional details.

Clem McDonald noted that he is working with a long-term care group in Georgia, using FHIR, which wants to use the CMS standard codes with OASIS to deliver them to CMS.

David McCallie, Cerner, asked what is the process and timeline that would allow a new use case and its standards to become relevant to the CMS incentive programs.

Elisabeth Myers said it would take time for CMS to make sure a new use case has more than one application. The information CMS gets from the ISP TF will affect how the certified EHR-based payment incentive programs evolve. CMS staff can discuss this in more detail.

David McCallie asked if there is a plan to have a 2020 Edition API, versus the 2015 Edition API that is required for use in 2019.

Elisabeth Myers said more information will be available this fall when ONC publishes the proposed rule to implement provisions of the Cures Act. Also, the unified agenda will be available around that time and may have helpful information.

Discussion of Priority Uses – Steven Lane and Kensaku Kawamoto, Task Force Co-chairs

Steven Lane and Ken Kawamoto transitioned the ISP TF to a discussion of priority uses. The co-chairs reviewed a slide listing the nine priority uses spelled out in the Cures Act, plus an additional priority – cross-cutting infrastructure. The discussion allowed each member to voice their comments, concerns and ideas about how to get to more specific priority uses, use cases, and associated standards.

Pointing out a few administrative details, **Steven Lane** reminded members to use the hand-raise feature in Adobe Connect if they have questions during the discussion. He noted that the detailed notes from each ISP TF meeting are posted to the HITAC portal, and all ISP TF members have access, but the notes are not part of the record available to the public.

Clem McDonald commented that he was unsure of the goal of this exercise. He asked if this is a way to decide access to certain types of data.

Ken Kawamoto answered that this is a way to start the dialogue - an attempt to go deeper into specifics of the priorities, including use cases and standards. If a member has a specific use case in mind and it does not fit into any of the Cures Act identified priorities, it most likely would fit within the added priority of cross-cutting infrastructure.

Steven Lane began the discussion by welcoming **Andrew Truscott, Accenture**, to the group and asked him to share thoughts about the priorities and how the ISP TF might orient itself to them.

Andrew Truscott said one item that should come out of the ISP TF process is how to realize the priorities for consumers of use cases and standards and how to help ensure adherence to the standards.

Arien Malec, Change Healthcare, noted this is a nice starting list of potential uses and shows good organizational structure. The ISP TF will need to make this a much more focused prioritized list in order to make progress through interoperability.

Cynthia Fisher, WaterRev, LLC, suggested that the list include side notes to view each priority from other perspectives, specifically patients' and caregivers'.

David McCallie enumerated several specific comments:

1. Patient Safety requires a standardized method to report safety issues that respects patient privacy but also captures the context for a near-miss.
2. There is a need to expand the capabilities for individual access radically. Patients will want to accomplish tasks such as making appointments and sending secure messages to and from their clinicians. The TF could support expanded patient access through APIs.
3. Registry reporting and access need to be standardized so that different registries that want data out of the EHR workflow could extract it consistently. This may fall under the clinical research priority. There are a number of projects underway, one at the American College of Cardiology, for example.
4. The upstream for clinical research should coalesce around a standard FHIR-based research data export format for various research communities.

5. Support for SMART apps could be expanded with the ability to create plug-ins to clinical workflow.

Edward Juhn, Blue Shield of California, agreed with earlier comments that it would be helpful to address how the priorities would impact broader fields such as population health, and how they impact the needs of the healthcare system versus the needs of the public.

Terry O'Malley noted the correlation between the U.S. Core Data for Interoperability Task Force (USCDI TF) work and the ISP TF's work. His concerns include specific use cases and fundamental processes such as attribution. This entails attributing individuals to clinicians, individuals to payers, or individuals in specific registries. "Is there a standardized method for attribution?"

He also noted the importance of unambiguously identifying the individual, asking; How will that be done? Who is the individual controlling the data? How do they grant permission? What are the specific use cases, such as the permitted uses listed under the Trusted Exchange Format and Common Agreement (TEFCA)?

Leslie Lenert, Medical University of South Carolina, pointed out that when specific tasks that use the same infrastructure are identified, those should be prioritized. He asked if the ISP TF can focus on a set of common methods that allow it to address several types of infrastructure at once. Some examples could be population health, public health, and research. The vocabulary may change, he said, but the approach could be the same.

Steven Lane welcomed Clem McDonald, representing the National Library of Medicine, and other members who could not attend the first meeting. He also noted that **Terry O'Malley** is a co-chair of the USCDI Task Force, whose work will tie in with this TF.

Jack Po, **Google,** agreed with many of the earlier comments. He emphasized that unique patient IDs and provider IDs are very important. Standardizing Clinical Decision Support (CDS) results would be helpful. There should be standards around how to add data back to CDS systems. He would like to see standardized requests for types of admissions. He also noted that the number of innovator apps will grow and there should be standards for how patients can view requests, allowing them to know who has accessed their data.

Ram Sriram, **National Institute of Standards and Technology**, said he would send an email with his comments to the TF.

Ricky Bloomfield, Apple, also agreed with many comments made previously. He added the TF could:

1. Look at the issue of financial transparency. This could go under the payment incentive plans priority. CMS has done some work to require health systems to release fee schedules.
2. Get private payers on board with Blue Button 2.0, to look at standardized outcomes in a way that is scalable. The International Consortium for Health Outcomes Measurement (ICHOM) provides an example (www.ichom.org). This could go on the list under the quality of patient care priority.
3. Reduce barriers for individuals to access health IT across multiple EHRs or portals, lowering the barrier to portal access. At present, requirements are very heterogeneous.

4. Consider a directory of FHIR endpoints or a way to make those endpoints and APIs more discoverable. What's needed is an automated system, like an RSS feed, for developers to find out when a new API is available. This could be placed within the individual access priority.
5. Consider adding consistent application of the encounter resource within Argonaut. Currently, the encounter resource has not been implemented in a scalable way across EHR vendors. For example, procedures and lab results are not tied to encounters programmatically.
6. Find a way to better use the provenance resource in FHIR. This would give a better sense of the origin of data and enhance the ability to edit data. It could be audited appropriately to understand the life cycle of information better.

Sasha TerMaat, Epic, noted several items:

1. Data capture and the impact on clinicians under quality measurement priorities.
2. Submission and transmission of data to clinicians. At present, clinicians don't have much insight into cost structure.
3. Expansion of FHIR apps.
4. Standardization of policies' terms of use. Patients need to know how their data is stored, further transmitted, and the possibility of it being deleted or made public. That information is difficult to find in lengthy legal documents.

Clem McDonald added that the ISP TF should keep in mind "one person's burden is another person's boon." Clem stated as an illustration, one of the challenges of cardiology registries is the extremely high cost to hospitals to collect the information and the ISP TF should consider who has to collect and provide the data, who bears that cost, and who benefits.

Tamer Fakhouri, One Medical, also agreed with previous comments. Tamer commented that the priority use areas are appropriate. He seconds the idea that benefit checking should be an area to look into as well as robust integration of EHRs with third-party apps and services and noted another important topic to discuss is standards around outcomes reporting.

Valerie Grey, New York eHealth Collaborative, agreed with the earlier comments.

Ken Kawamoto said that under the privacy priority it is important that only minimum required data be shared for FHIR scopes, agreement is needed on a publicly accessible set of detailed clinical models and deeper definitions should be required for some items.

Andrew Truscott agreed with **Ricky Bloomfield**'s comments agreeing that it is extremely important, he said, to pay attention to standardized infrastructure components. Andrew continued by saying the TF should make sure it does not forget both provenance and context and their role in making interoperability successful and in clinical decision support, it is important to ensure that the information in those alerts and the decisions that were made in response persists.

David McCallie noted that the mechanics of interactive care planning are extremely important. Static documents will not be good enough for population management, adding this could go under the cross-cutting infrastructure priority.

PUBLIC COMMENT

The following public comment was received in the chat feature of the webinar during the meeting:

Laura Hughes: has the team considered the GDPR and medical tourism?

(Note: GDPR refers to the European Union's General Data Protection Regulation.)

NEXT STEPS:
The co-chairs will edit the priorities list, adding members' comments, and send the document out to TF members, so it is available for discussion at the next meeting. Members who could not comment on the list today will have the opportunity at the next meeting.

The next meeting of the TF is scheduled for August 14, 2018, from 10:00 am to 11:30 am ET. The next full HITAC meeting is on September 5, 2018. All meeting dates and specifics are posted on the healthIT.gov website.

Lauren Richie adjourned the meeting at 11:30 am.