Health Information Technology Advisory Committee
Interoperability Priorities Standards Task Force
November 27, 2018, 10:00 a.m. - 11:30 a.m. ET
VIRTUAL

The November 27, 2018, meeting of the Interoperability Standards Priorities (ISP) Task Force (TF) of the Health IT Advisory Committee (HITAC) was called to order at 10:02 am ET by Lauren Richie, Office of the National Coordinator for Health IT (ONC).

ROLL CALL

Members in attendance

Kensaku Kawamoto, co-chair, University of Utah Health
Steven Lane, co-chair, Sutter Health
Arien Malec, Member, Change Healthcare
Clement McDonald, Member, National Library of Medicine
Andrew Truscott, Member, Accenture
David McCallie, Jr., Member, Cerner
Edward Juhn, Member, Blue Shield of California
Leslie Lenert, Member, Medical University of South Carolina
Ming Jack Po, Member, Google
Raj Ratwani, Member, MedStar Health
Ram Sriram, Member, National Institute of Standards and Technology
Ricky Bloomfield, Member, Apple
Sasha TerMaat, Member, Epic
Terrence O'Malley, Member, Massachusetts General Hospital
Tamer Fakhouri, Member, One Medical
Victor Lee, Member, Clinical Architecture

Members not in attendance

Cynthia Fisher, Member, WaterRev, LLC
Tina Esposito, Member, Advocate Health Care
Sheryl Turney, Member, Anthem
Scott Weingarten, Member, Cedars-Sinai Health System
Valerie Grey, Member, New York eHealth Collaborative

ONC Staff

Caroline Coy, Branch Chief, Strategic Initiatives
Farrah Darbouze, Public Health Analyst, ONC ISP Task Force Lead
Lauren Richie, Branch Chief, Coordination, Designated Federal Officer

Laruen Richie called the meeting to order, conducted roll call, and then turned the meeting over to the co-chairs.

Introduction

Steven Lane welcomed the task force and reviewed the agenda. He shared that there were a few planning meetings that occurred prior to today's meeting. He also mentioned that due to a few competing priorities, the agenda is a little light so the meeting may end early. Matt Menning from Integrated Health Model Initiative (IHMI) will provide an overview of what IHMI does. There will also be a discussion of the FHIR messaging standards. There may be a need to separate out the functionality from the standards needed to perform the functionality. He noted that there are competing standards within the industry, but the ISP TF will focus on where standards exist and where they need to evolve.

He also shared that he, Terry O'Malley, and Ken Kawamoto have been working on a document to help get to recommendations.

He is also working on a clinical validation document that was created and shared with the American Medical Association (AMA) Integrated Health Model Initiative (IHMI). The document is based on what the ISP TF heard from the 360x project that standards are lacking to support the referral process. The document proposes that the AMA takes this on to develop best practice standards to support the referral process. The document will be shared with the ISP TF.

He then transitioned to a presentation from Matt Menning.

Integrated Health Model Initiative (IHMI) Overview, Matt Menning

Matt Menning noted his appreciation for being able to participate. Once the clinical review group convenes, he will be able to provide additional feedback on the document that Steven Lane is planning to share on behalf of the ISP TF.

IHMI is aimed at the quality of data being exchanged in clinical health. America spends over three trillion dollars a year on health care and generates more health care data than ever before. Yet, some of the most meaningful data is still inaccessible and incomplete.

IHMI was launched over a year ago. The vision is to move forward by enabling meaningful information exchange. One of the strengths of the AMA is its ability to convene and use resources to ensure that data being exchanged is semantically interoperable and includes gaps (e.g., interoperability and clinical impact, inclusive of state, functional, and social determinants of health).

He noted that sharing data is improving between systems and organizations, but in the absence of standards for capturing and representation, the ability to use the data for outcomes is lacking. The goal of IHMI is to ensure that when exchanging data, it is usable across the entire flow of information, clinically relevant, and can be trusted to support clinical decision making.

The IHMI has a narrow focus for the next six months on areas where there is a high need and there is a high likelihood that it will be adopted. The current focus is on patient-generated health data (PGHD), on the Internet of Things (IoT) in particular. There is very little insight into what data is being collected by apps, not sure who is deciding if the data is the right data, and there are almost no standards around what

is the right data. There will be a focus on remote monitoring data related to three diseases states: 1) Hypertensions, 2) Diabetes, and 3) Asthma and data collected from asthma sensors. Both clinical data and non-clinical data (e.g., functional status, social determents, and goals) will be evaluated.

AMA is the right organizations because of their ability to convene the right players to address the problem and represent the interests of patients and physicians. AMA is an honest broker. Working on tools to address the problem of interoperability and not just advocacy. Leveraging this work will help AMA support the interoperability problem in healthcare. AMA can convene medicine and technology around market-driven solutions that are meaningful to clinical practice. AMA can create a framework that can be leveraged by all content and standards developers to enable impactful use cases with inherent agreement on utility as well as standards of quality and consistency. It is important that the work product of IHMI be easy to consume and allows developer, aggregators, and implementers to implement into systems. The intent is to create a sustaining business model that sustains the work of IHMI and for folks generating content to be modeled and used within the imitative.

Matt Menning leads engagement and participates in calls similar to this one and understand problems to drive clinical content submissions. IHIM will be reviewing the submission from this group. Many organizations meet to model the information consistently to continue to be able to scale and understand the data. There is a focus on device manufactures making the data more actionable for a real impact to make care decisions based on that data.

Discussion

Ricky Bloomfield asked how this work compares with Health Level 7 (HL7) Clinical Information Modeling Initiative (CIMI) and Open mHealth.

- **Matt Menning** noted that the goal is not to duplicate work but to bring alignment to the massive amount of good work happening. There are tedious discussions about how best to model clinical content and which kind of modeling should be used. The goal is to find a way to agree on a common standard for use and understanding of clinical content. The discussion will center around hypertension and blood pressure. Doing a lot of work similar to CIMI, but differentiate by making the content as easy as possible to implement the content and move at the speed of the market. This is not a volunteer or consensus driven organization. Hoping to advance work by staying in with the speed of the market. HL7 gets to the liquidity versus portability question. IHMI is agnostic to how data will be exchanged. The goal is not to facilitate the exchange of data, but to facilitate the usability of the data on both ends. Matt shared that he was not aware of the work that Open mHealth is doing.
- **Ricky Bloomfield** shared that Open mHealth's goal is to have an open standard around patient generated data. There are a number of groups participating. It is based in California so a bit west coast centric. Their model is opensource and freely available.

Clem McDonald questioned if the goal is to mostly try to exchange data living in machines to not add an additional data entry burden on providers. There are existing models for sending data elements on with particular requests. There are order entry models to think about. Joel Buchanan from Wisconsin has developed a list of diseases and drugs that are linked by problems. Individual reasons for a referral have special templates and will be harder to develop.

Steve Lane noted that there are a lot of groups that could potentially be collaborators in this work. The ISP TF can suggest a convener of the groups to support this work. Once a strategy is established, it can help the industry.

Ken Kawamoto noted that AMA can provide clinical consensus for common referrals. This initiative is intending to license the models, in comparison, HL7 allows things to be publicly available. Need to be aware of the consequence of participating with AMA as clinicians may need to pay a licensing fee.

- **Matt Menning** questioned whether licensing of content should be discussed in the ISP TF.

- **Ken Kawamoto** wasn't sure this was the right group. He noted that there are barriers for license content, it is a bit of a tough nut to crack, as ideally want it free and to be rich. This is something that might need to be discussed in another venue. Other standards have been paid for by another group or such a high priority area that organizations are essentially paying for the work to be done.

Andrew Truscott commented that it is good to see that the AMA has taken leadership. He noted that he is concerned that the program of work is addressing things that are already being or have been addressed. He questioned whether that was deliberate because it wasn't addressed correctly?

- **Matt Menning** commented that IHMI started with hypertension to build on work that was already started with the American Heart Association. Concern was not about the quality of work that others were doing, but to build on work happening in another area of the organizations and to address a gap for modeling PGHD. It surfaced a need to think about sensors and remote monitoring devices.

ISPTF Recommendation Discussion

Steve Lane noted the need to start to structure recommendations. There are a lot of folks involved in trying to develop and support standards and want to provide meaningful input.

He also noted that the 360X work is great and deals with particular functionality, but it leads to the discussion of content and payload of exchange. There is administrative content about prior authorization. Identified that there are different standards that the industry is working out. Don't have the expertise or the time to wade into that. There is an opportunity to look into FHIR or other standards to support the exchange itself.

Terry O'Malley shared that governance is an important item that should be looked at and there may be standards to support governance that needs to be looked at.

Steven Lane noted issues of permissions and authorizations. 360X put a lot of things out of scope which included some important pieces that are needed to exchange information (e.g., patient identifiers, authorizations for information exchange). These are important items that need to be in place to share data. There are a lot of things beyond syntax and transport standards.

Steve Lane noted that the work has been more free form around orders and results. Questions how it would be most valuable to structure recommendations that can be brought back to the next meeting.

Clem McDonald shared that it is going to be hard. It has been 15 years to get to a patient identifier. Concerned about getting stuck on the hardest part.

Andrew Truscott noted in regards to the patient identifier that there might be work. He asked ONC to provide additional information on this. Could also look to leverage work that others are doing. In regards to structure, he would recommend the different domains of standard (i.e., syntax, semantic, provenance, context, and governance).

Sasha TerMaat commented that she is struggling to parse out the challenges. A challenge has to do with identifying all the actions related to one particular referring episode. There are also different use cases in regards to the patient (e.g., scheduling, patient role in the process). It might be helpful to link how the recommendations can address the different players.

Ken Kawamoto commented that what he heard from Sasha was to get down to the problem that is being solved, enumerate it, and then organize and summarize thinking around this.

Sasha TerMaat noted that a lot of problems have been discussed and should be noted in recommendations.

Ken Kawamoto shared that when the desire is to refer outside of organizational bounds, it is hard to make sure that the information goes to the referred specialist and back. He noted that 360X helped to map out the problem.

He suggested that recommendations may be for the 360X project to be continued and should support moving forward towards real uses, as there currently isn't sufficient piloting. There is an effort to identify the specialty specific referral needs and there will be a need to ask a group to convene those folks to leverage existing work.

He also suggested recommending further analysis around continuing down the Direct path. There also is an infrastructure need, as Direct may be pushed to its limits.

Les Lenert suggested that ONC could put out a request for answers.

Ken Kawamoto suggested that ONC conduct an analysis. The analysis may identify that work should continue to build on 360X and Direct. He noted that there should also be an investment in what a FHIR based structure should look like.

- **Terry O'Malley** commented that 360X is a great example of a closed loop referral, but it isn't the only closed loop referral in health care. He suggested identifying how to leverage the 360x platform for transitions of care, lab ordering and results, and ongoing longitudinal care.

- **Leslie Lenert** commented that no one group is going to look at another group's work and realize they should have done something different.

- **Ken Kawamoto** noted that consolidation may need to happen.
- **Leslie Lenert** questioned if consolidation was within scope for the ISP TF.
- **Ken Kawamoto** noted that an analysis needs to be done on specific standards, but the ISP TF is not currently there yet.
- **Leslie Lenert** noted that someone needs to push to get decisions made. Otherwise, the result will be different standards and approaches.
- **Unidentified Speaker** suggested a need to start a demonstration project of some kind to develop real-world problems. Need to test the 360X approach and should be done as soon as possible.
- **Leslie Lenert** noted that there are organizations that may already be doing this work.

Terry O'Malley noted that governance is a barrier for entry. He suggested that a snap on governance structure should be part of the process.

Steven Lane noted that the Trusted Exchange Framework and Common Agreement (TEFCA) could provide a home for the type of governance being discussed.

- **Andrew Truscott** noted that he assumed the ISP TF would try to align with TEFCA.
- **Steven Lane** noted that within the recommendations it should be noted that there should alignment with TEFCA.
- **Clem McDonald** agreed with this approach.
- **Sasha TerMaat** expressed concern for endorsing without knowing what is in TEFCA.
- **Andrew Truscott** commented that there is a presumption that it is an appropriate model.

Lauren Richie transitioned to public comment.

Public Comment

There was no public comment.

Next Steps

Ken Kawamoto shared that there may be a need to alter the meeting schedule due the holidays and other ONC/HITAC priorities.

Steven Lane committed to sharing the draft IHMI document and a process document for review and input by ISP TF members.

The next meeting of the ISP TF is currently scheduled for December 11, 2018, at 10:00 am.

The meeting was adjourned at 11:27 a.m. ET